the Canadian Nurse

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MONTREAL

NOVEMBER 1964

SERIES ON PUBLIC HEALTH NURSING

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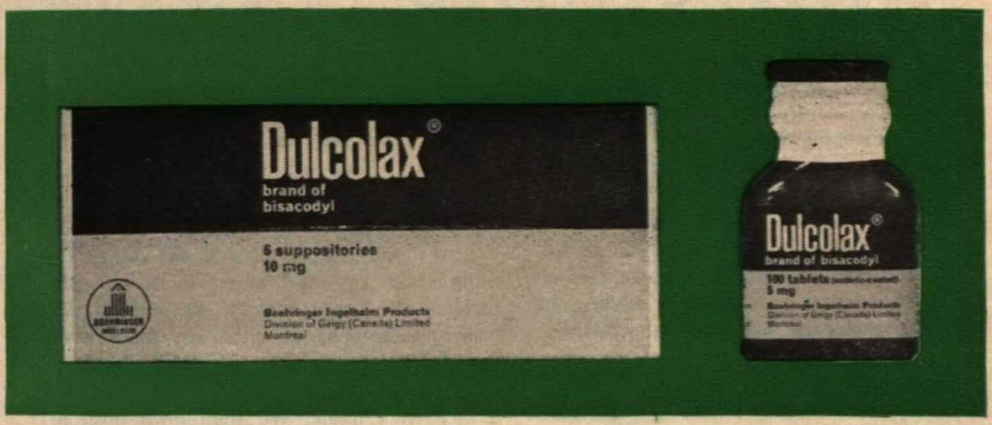

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Between Ourselves

We are all familiar with the wide variety of specialization in the field of medicine. Though differing in many respects from our medical confreres, there is also considerable diversity in the areas of work in which nurses engage. Many of us realize that public health nursing is a distinct speciality. Few of us realize what a broad spectrum of activity is included within this field. You will be much more aware of all of this when you have finished reading the excellent series of articles that constitute this issue.

Thousands of babies are taken to clinics to be weighed, to receive their immunization "shots," to have a complete physical examination. However, few of us can recall those experiences. Excepting those who have had to go to hospital as youngsters, most children associate "nurse" with the pleasant person they meet during their years at school.

The old time public health nurses would scarcely recognize the school nurse's office and program in its modern garb. ALICE BEATTIE gives an excellent picture of what is new and practical.

Every nurse has been well grounded in the problems of communicable disease control. However, when you read DR. MOTT and MISS FERNIE'S article you will be amazed at how rapidly the situation has changed from even ten years ago.

You will not only be amazed but perhaps even horrified by the unfortunate facts regarding the resurgence of the venereal diseases within recent years. DR. SMITH points out that at one stage the annual statistics seemed to indicate that within a relatively short time both gonorrhea and syphilis might almost disappear from the Canadian scene as many other of the communicable diseases have done. Unhappily, the workers in this field now seem to be back almost where they were when the so-called "wonder drugs" were first used.

And did it ever occur to you that there are an unbelievable number of parents who do not know how to teach their children to play? Oh yes, they give them toys — the more intricate and expensive the better. ANN GIBSON reveals some very interesting sidelights on this matter of children's play interests.

Too many hospital-employed nurses tend to look askance at an issue of their *Journal* that is made up almost entirely of articles dealing particularly with public health nursing. "This is not for me!" they say. Try them out! You will find many items of genuine interest.

* * *

Last month we promised to tell you something about two new members of our editorial staff. Unfortunately, we still do not have photographs of either of them even though we know that everyone feels so much better acquainted when they can put a face to a name. We shall prod both of them into having their pictures taken. In the meantime, just a few items about the new editorial set-up.

CLAIRE BIGUÉ, who has been with the *Journal* as assistant editor, French, since October, 1961, has now assumed the responsibilities of associate editor.

MARGUERITE MORIN joined our staff last September to fill the post of assistant editor, French. Born at Labelle, Quebec, Miss Morin is a graduate of Hôtel Dieu de Québec. She received her B.Sc.Ed. from L'Institut Marguerite d'Youville, her M.Sc. from St. Louis University. She has had broad experience in schools of nursing, both in Canada and in Europe.

GLENNIS ZILM came to the *Journal* on October 1 as an assistant editor, English. Born in Parkman, Sask., Miss Zilm enrolled in the degree course program of the University of British Columbia, receiving her professional training at the Vancouver General Hospital. She has had experience as both a public health nurse and a clinical instructor.

You will hear much from these people in the months to come.

A Department of Health, Education, and Welfare employee, according to the *Long Island Press*, was vacationing in New England and asked a sweet old lady of 71, "what do you think of Medicare?" "I don't know for myself," she replied, "but I have a friend who tried it and lost 21 pounds."

— *A. J. N.*, July 1964

THE CANADIAN NURSE

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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of THE CANADIAN NURSE *nor of the Canadian Nurses' Association.*

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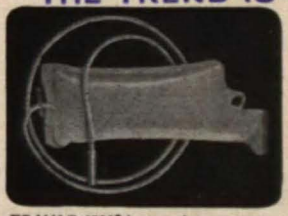

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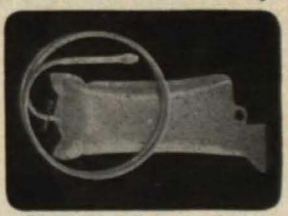

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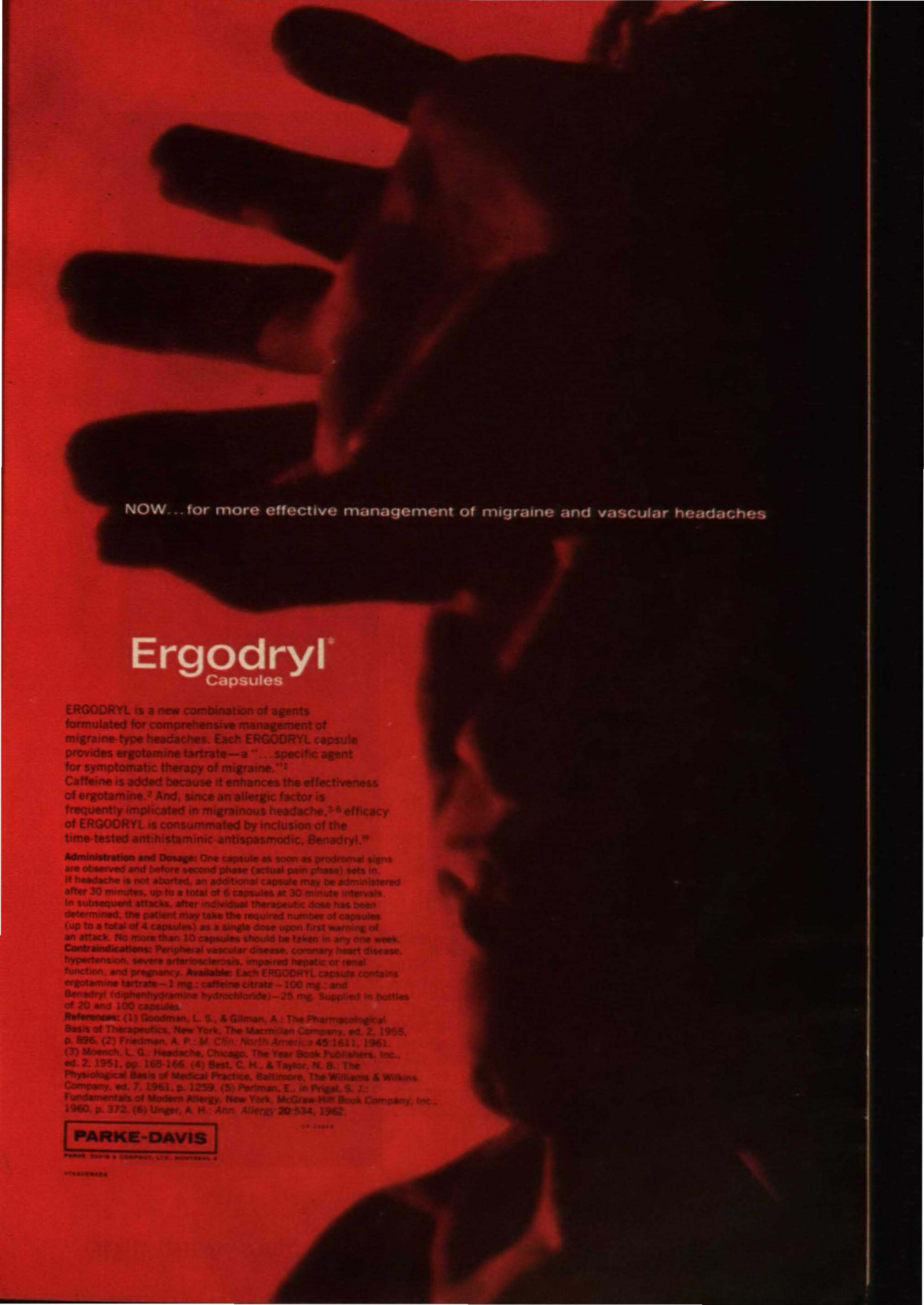

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References: (1) Goodman, L. S., & Gilman, A.: The Pharmacological Basis of Therapeutics, New York, The Macmillan Company, ed. 2, 1955, p. 896. (2) Friedman, A. P.: *M. Clin. North America* **45**:1611, 1961. (3) Moench, L. G.: Headache, Chicago, The Year Book Publishers, Inc., ed. 2, 1951, pp. 168-166. (4) Best, C. H., & Taylor, N. B.: The Physiological Basis of Medical Practice, Baltimore, The Williams & Wilkins Company, ed. 7, 1961, p. 1259. (5) Perlman, E., in Prigal, S. J.: Fundamentals of Modern Allergy, New York, McGraw-Hill Book Company, Inc., 1960, p. 372. (6) Unger, A. H.: *Ann. Allergy* **20**:534, 1962.

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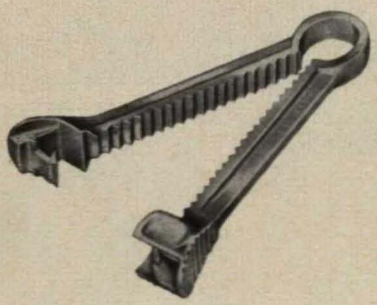

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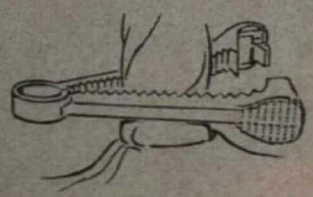

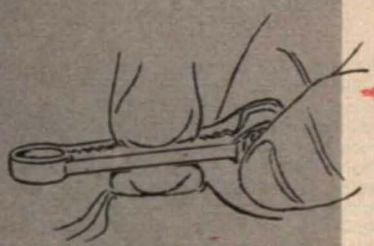

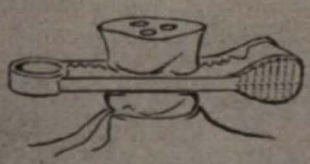

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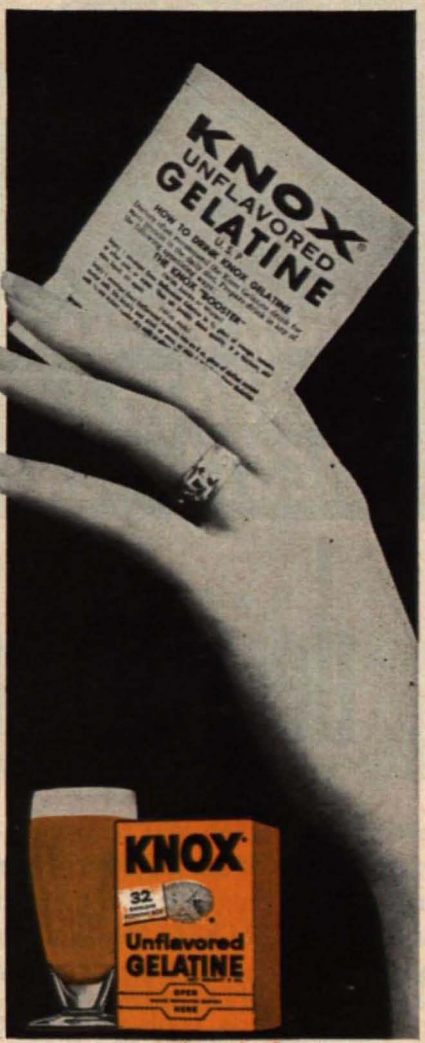

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- ☐ 1. Rosenberg, S., Oster, K. A., Kallos, A. and Burroughs, W.: A.M.A. Arch. Dermat. **76**:330, September, 1957.
- ☐ 2. Derzavis, J. L. and Mulinos, M. G.: Med. Ann. D. C. **XXX**:133, March, 1961.
- ☐ 3. Schwinner, M. and Mulinos, M. G.: Antibiot., Med. & Clin. Therapy **4**:403, July, 1957.
- ☐ 4. Rosenberg, S. and Oster, K. S.: Conn. State Med. J. **19**:171, March, 1955.
- ☐ 5. Tyson, T. L.: J. Invest, Dermat. **14**:323, May, 1950.

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Random Comments

Dear Editor:

Our library is in need of back issues of *Nursing Outlook* for the years 1953, 1954, 1956 and for November and December, 1955.

If any readers of *The Canadian Nurse* should have all or part of these and would let us have them, we would be happy to pay mailing charges.

Mabel C. Brown, Librarian,
The Atkinson School of Nursing,
Toronto Western Hospital,
399 Bathurst St., Toronto, Ont.

Dear Editor:

I commend you on the many excellent articles appearing in the *Journal* that are written by students. I enjoy them very much.

Maureen C. Herrington, Ont.

Dear Editor:

As a non-nursing but interested reader of *The Canadian Nurse,* perhaps you will excuse me making a comment on G. Zilm's article "Keep Cool."

All the advice given is sound, but it seems unfortunate that the necessity — in the opinion of the writer — for the treatment as prescribed is made necessary "since most hospital administrators still regard air conditioning in patient areas as a luxury."

It is my opinion that the blame is not so easily allocated to one individual. An administrator has to make do without many things; and should he regard air conditioning as a luxury, he is in the company of many architects, directors of nursing, board members and others, who, after counting the cash, decide to proceed with standard construction.

I wonder what would be the decision of many nurses if they were given the choice of better-than-average patient area with no air conditioning, or just adequate patient area with air conditioning.

Considering that air conditioning is not yet regarded as necessary in many of our better homes, how could we approach the less affluent members of our society for a donation to install this "necessity"?

James L. Roberts

¶ *Mr. Roberts is administrator of the Cottage Hospital, Pembroke, Ontario.* Ed.

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THERE'S ALWAYS SOMEBODY . . .

A psychologist was recently quoted as saying that a hospitalized child should be permitted to have his favorite pet at the bedside — to give him a sense of security.

Now, lest any reader has her hand on the phone, ready to report us to the S.P.C.A., we hasten to state, very emphatically, that we *love* animals; furthermore, we believe that each child should have his own. As we see it, however, several questions must be answered before we jump into this "pet deal."

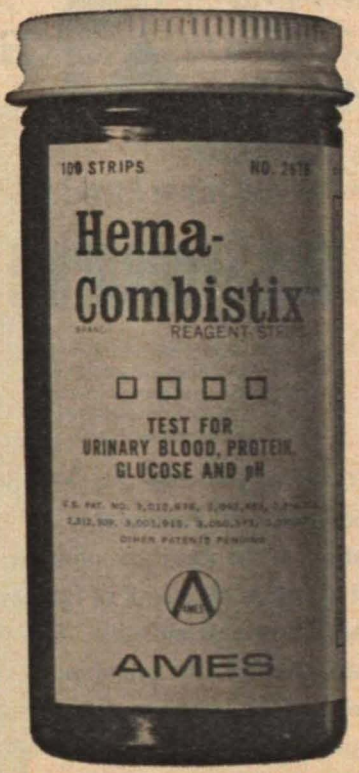
1. *What* will we move *out* of the bedside table to make room for this wee beasty?
2. *How* will we provide security for the *nurse?* Many little boys of our acquaintance collect mice, rats, snakes, frogs and tadpoles as pets.
3. How will the diet kitchen react to a rush order of warm milk in a bowl with a dash of catnip, 20 pieces of mild Cheddar Cheese, three flies and some dog food?
4. Will the purchasing department agree to supply one bar of flea soap for each patient unit?
5. What new skills will the occupational therapist be required to learn so that she can effectively meet the recreational needs of this 4,8 or 12-legged creature?
6. Will the unions agree to add an extra clause to their contract, i.e. "Mop floors q.1/2 h."?

These are indeed obstacles which might prove to be rather frustrating. By far the most crucial problem, however, will be this: *How* or *where* can we possibly add another subject — animal husbandry — to our already overburdened nursing curriculum?

We recognize this "pet issue" as a challenge to all. Perhaps if a committee could be organized, with representatives from all the various disciplines involved . . . .

SELF-DEVELOPMENT

A person who habitually chews photographic film may find his hands and face turning blue. A New Mexico physician made this discovery after examining a television studio worker who had the nervous habit of nibbling scraps of film. His body apparently absorbed chemicals from the film; then exposure to light on his hands and face "developed" him. — *Horner Newsletter*



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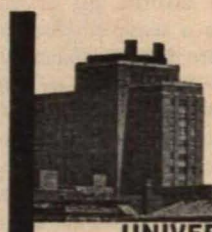

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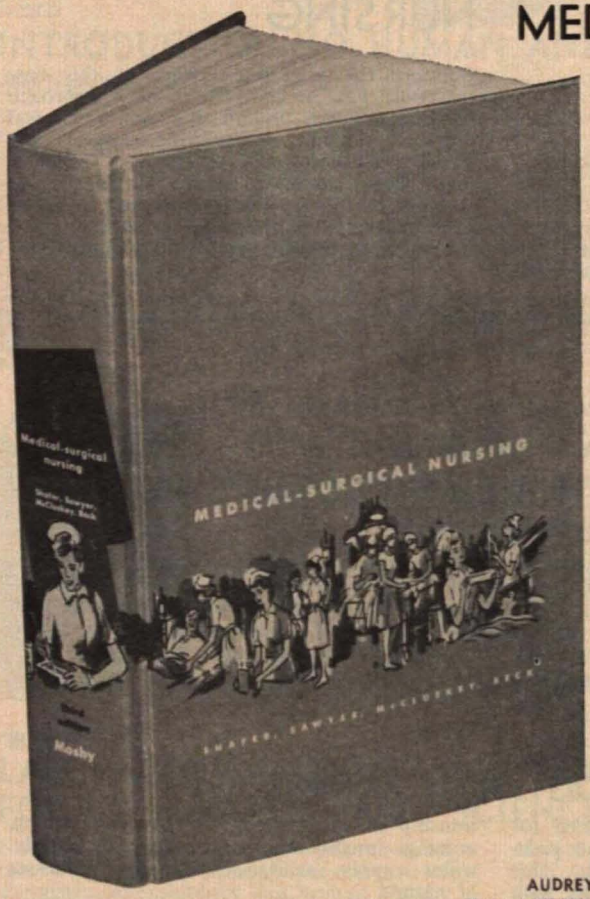

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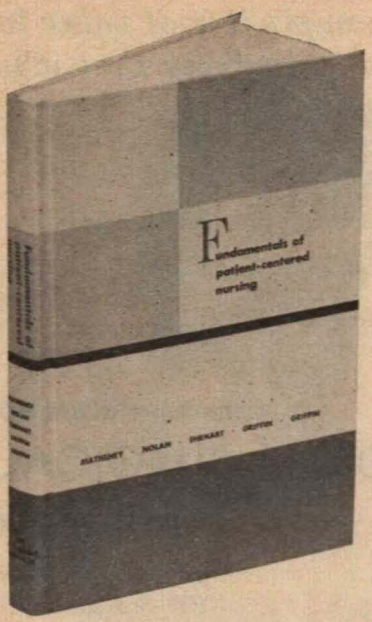

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Some 10,000 nurses, or nearly four-fifths of these canvassed, responded. The reason most often given for inactive status was, "I believe a mother should be in the home while her children are young." The second-ranking reason was inability to make suitable arrangements for care of immediate family. Other major reasons included low salaries of nurses and difficulty in arranging working hours compatible with home responsibilities.

Some 4,500 of the respondents said they expect to return to nursing, either full-or part-time. The majority of those who intend to return within three years want to take "refresher" courses to reorient them to current practice.

The results of the study suggest that working schedules should be developed in the light of the part-time availability of nurses and that day centres be established for the care of their preschool and school-age children.

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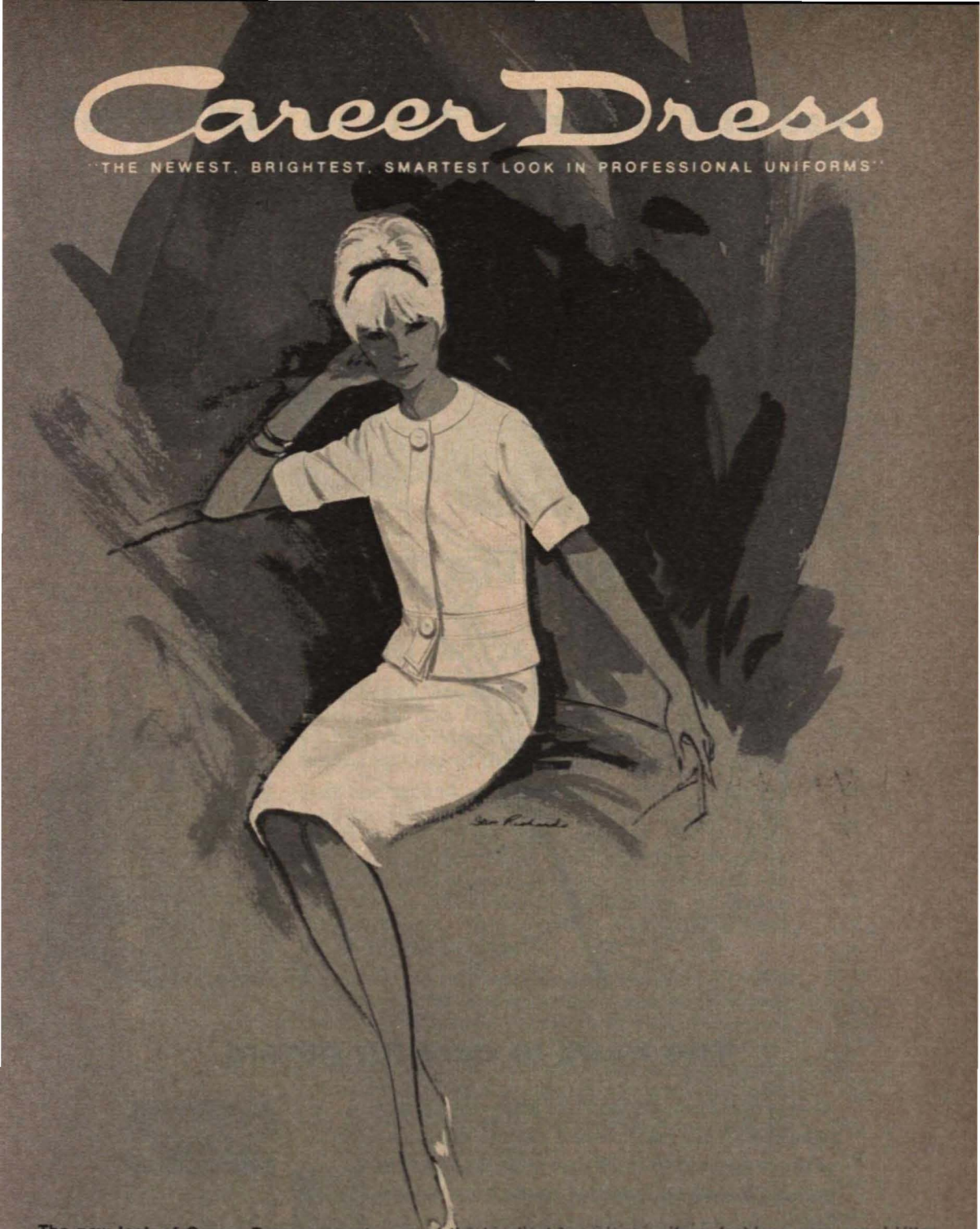

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VOLUME 60 MONTREAL, NOVEMBER 1964 NUMBER 11

COMMUNICABLE DISEASE

Yesterday, Today and Tomorrow

G. A. MOTT, M.B., D.P.H. *and* JEAN P. FERNIE, R.N.

Control of major communicable disease is one of the brightest stars in the public health crown. The price of control, however, is eternal vigilance and there are yet other laurels to be gained.

HISTORICAL CONSIDERATIONS

Communicable disease has played a prominent part in shaping the history of mankind. It has caused or prevented movements of population; it has helped determine the victors and the vanquished in military campaigns; it has seriously interfered with industrial development; and it prevented, for years, the completion of engineering enterprises, notably the Panama Canal. Public reaction has frequently been one of panic arising out of fear of something which was not understood and which could not be controlled.

Before the birth of bacteriology at the end of the nineteenth century, control methods were empirical only; but where they were based on accurate observation and logical inference they were frequently successful. Jenner's discovery of vaccination had to wait two centuries for a logical scientific explanation and Snow's epidemiological investigations proved that cholera was water-borne before the Vibrio was discovered. Today, control methods are based on both the deductive application of scientific fact and the inductive reasoning of epidemiological investigation.

NATURE AND CONTROL

Epidemic disease occurs when an infectious agent begins to spread rapidly among a susceptible population. The

Dr. Mott is Deputy Medical Health Officer, Greater Vancouver Metropolitan Health Service. Miss Fernie is Supervisor, Fairview Pavilion (Infectious Diseases), Vancouver General Hospital, B.C.

severity of the disease in individuals and the extent of the spread throughout the population depend on the balance between *the virulence of the infectious agent* and the *resistance or lack of it in the population host*. There is a third factor involved, namely, *the environment* in which the host is living which may be favorable or unfavorable for the dissemination of the infectious agent, and the development of disease in the host.

These three factors — agent, host and environment — may be called the epidemiological trinity and the infectious morbidity in a population or an individual is the resultant of the combined effect of all three. In an epidemiological analysis of an epidemic situation it is necessary to consider three factors:

1. The reservoir in which the infectious agent lives and multiplies and the portal of exit whereby it escapes from the reservoir.
2. The vehicle whereby the infectious agent is transferred across the environment to the new host.
3. The portal of entry in the new host and the resistance of the new host.

In all cases, methods of control reduce themselves to one or more of the following:

1. Measures against the agent in its reservoir.
2. Measures to prevent the escape of the agent into the environment and to prevent its transfer to a new host.
3. Measures to increase the resistance of the new host.

Each of these will now be examined separately and in detail.

Agent in Its Reservoir

The reservoir of an infectious agent may be *human* or *animal*. The human reservoir consists of actual, recognized, frank cases of the disease, subclinical unrecognized cases of the disease and symptomless carriers. Carriers are commonly the origin of outbreaks of typhoid and diphtheria and unrecognized subclinical cases of the disease are common in outbreaks of poliomyelitis and infectious hepatitis. The animal reservoir consists either of diseased animals, e.g., rabid dogs, tuberculous cattle, or healthy animals harboring a parasite pathogenic for man, e.g., urban typhus in rats.

The agent may be attacked in its human reservoir by chemotherapy or by surgery. The treatment of a case of infectious disease by antibiotics, e.g., streptococcal sore throat or scarlet fever treated with penicillin, in addition to helping the individual patient also reduces the reservoir of the infectious agent. Removal of a diseased gall bladder from a typhoid carrier will often render the stools negative.

The agent may be attacked in its animal reservoir by destruction of the animal host, e.g., slaughter of tuberculin positive cattle, destruction of rabid dogs, war on the rat. It is sometimes possible to destroy an animal reservoir completely by these methods as has been done with tuberculosis in the cow; but the human reservoir can only be reduced and never eliminated by these methods.

Environmental Control

Environmental measures for the control of communicable disease may be:

1. *General:* This includes all the nonspecific measures which may improve living conditions, such as good housing, good food, good sanitation, pure water supply, safe milk supply. The mass vehicles of water and food must be protected from contamination by an infectious agent, by appropriate preparation, handling and treatment; and a high general standard of living raises the resistance of the host. These are traditional public health measures, which dominated public health practice in its early days and derived especially from Chadwick and Shattuck, who pioneered public health in Britain and U.S.A. respectively.

2. *Specific:* This involves protecting the environment from contamination with an infectious agent so far as possible and where this is not possible, preventing the infected environment from involving a new host. This is accomplished by isolation and quarantine and the handling of the infected person. It includes such things as control of the chronic typhoid carrier, and the operation of an infectious diseases hospital. For many years, these methods were the only ones available for the control of communicable diseases and, while other methods are now available, the care of an infected person in hospital nursing practice still involves an important and specialized technique. The general principle is to prevent the infectious agent being transferred from

its reservoir in the infected person across the environment to a new host and it should be remembered that in such a transference the vehicle may be:

a. inanimate, such as clothing, bed linen, crockery, the atmosphere, etc.
b. human animate, e.g., the hands of the attendant.
c. non-human animate, e.g., flies.

ISOLATION TECHNIQUE

In spite of the value of modern chemotherapy, the nurse in the hospital setting still holds in her hands the key to the successful recovery of the patient and the control and prevention of cross infection by careful isolation technique.

Ideally, patients should be admitted or transferred to an isolation hospital and nursed in single rooms. Failing this, the smallest ward area should be used and isolation techniques established. The barrier to environmental contamination and cross infection is imaginary and only as effective as the conscience and skill of the staff make it.

Preparation of Unit

1. Situate the patient as near to washing facilities as possible and away from heavy ward traffic.

2. Use plasticized mattress and pillows. Failing this, cover mattress and pillows with rubber sheeting.

3. Place screens around the bed and consider the area within the screens contaminated.

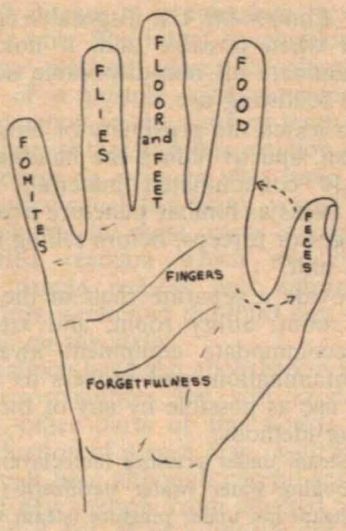
4. Collect the following articles for use within the unit:

a. Bactericidal handwash, such as pHisoHex;
b. Dispenser of paper towels;
c. Waste paper basket lined with a plastic bag;
d. A small hamper for soiled linen;
e. Paper bags;
f. Supply of newspapers for wrapping waste food and garbage;
g. Disposable bed pan covers.

5. Place the following articles outside the unit:

a. Isolation gowns;
b. Masks;
c. Large hamper for soiled linen;
d. Large garbage can lined with a plastic bag;
e. Large paper bags.

6. In the utility room, service room and kitchen, provide a method of decontamination.



Main Dangers in Prevention of Cross Infection

Double Bagging

Both small and large plastic, linen, and paper bags are used. Articles for disposal, laundry, or decontamination, are first placed in the small bags within the unit, and then placed in the large bags outside the unit. For this procedure, two persons are required: one to place the small bags in the large bags; the other to handle the large bags with uncontaminated hands. This means that the outer side of the large bags is considered clean for transport.

Precautions

1. *Handwashing:* Wash hands between all procedures and after handling contaminated articles. Clean paper towels are used to handle contaminated articles too large to be placed in the paper bags when being removed from unit for decontamination.

2. *Isolation Gowns:* Gowns are worn when one's uniform is likely to come in contact with the patient or equipment. The gown is put on before entering the unit, worn once only, and then discarded into the linen bag *within* the unit.

3. *Masks:* Masks are worn when the causative organism is in the throat, nose, or sputum. They are worn once only and discarded just before leaving

the unit. Only the ties of the mask are handled. If appropriate, that is, if the patient's condition permits, the patient may wear the mask.

4. *Equipment:* Use disposable equipment when possible and, if not, decontaminate all non-disposable equipment following use.

To lessen the possibility of cross infection, and to reduce the handling of grossly contaminated material, rinse such items as lumbar puncture needles, syringes or forceps, before taking them from unit.

Provide a separate shelf in the service room, utility room, and kitchen to accommodate equipment awaiting decontamination, and process as soon after use as possible by any of the following methods:

a. Steam under pressure (autoclave);
b. boiling water (water sterilizer);
c. steam not under pressure (steam sterilizer);
d. wash with disinfectants.

Use the first three methods for articles such as trays, instruments, syringes, needles, dishes or cutlery; use the fourth method for articles too big for the sterilizers or for those that do not tolerate heat or moisture.

Decontaminate before washing to lessen the handling of contaminated equipment.

5. *Excreta:* If causative organism is in feces or urine, place disinfectant in bedpan prior to discarding contents in the usual manner.

6. *Floors:* Floors are considered heavily contaminated. Nothing but *feet* should be on the floor.

7. *Terminal Cleaning:* Non-disposable equipment is treated by any of the four methods of decontamination. Walls and floor are washed with disinfectant solution and curtains replaced.

The above procedures and techniques can be adapted to any situation; all personnel working in the area must be familiar with them. Explanation and consideration must be given to patients and to their relatives to help them accept the isolation procedures deemed necessary.

Outside the hospital, much less attention is now directed to isolation and quarantine than formerly. If a patient requires strict isolation technique, he should be sent to hospital. If not, and he remains at home, the simple exclusion of susceptibles from his vicinity during the infectious period is all that is required. Quarantine of contacts is hardly practised now except in diphtheria and smallpox, though legal provision for it still exists in many provinces.

HOST RESISTANCE

If an infectious agent gains lodgment in a new host through breakdown of the two preceding methods, the resultant disease will depend qualitatively and quantitatively on the balance between agent virulence and host resistance. Host resistance is of two kinds.

1. *General:* A healthy person living in a healthy environment will be much more resistant to the infectious agent than a person in poor health living in slum conditions. Hence, the promotion of healthy environmental conditions contributes considerably to general host resistance to disease.

2. *Specific:* A person's resistance to a specific infectious agent depends to a large extent on the presence of specific antibodies in his blood. The control of communicable disease today depends greatly on the discovery and exploitation of methods of providing specific host resistance by the process of immunization. This method now far outweighs in importance the older methods of isolation, quarantine and fomite control.

When an infectious agent enters man, the body reacts by providing a neutralizing substance and, when enough of this has been produced, the person becomes immune to the disease. The part of the agent causing this to happen is called an *antigen* and the neutralizing substance produced is called an *antibody*. The same reaction occurs in animals. In the natural course of events when the disease is acquired, the antibody is produced slowly. At the end of the disease, if the patient survives, in many diseases, sufficient antibody is left to protect against a further attack.

Specific immunity may be produced artificially by two general methods.

1. *Active immunity:* The infectious agent is altered so that it retains its antigen, but loses the power to produce disease; the

altered agent is then administered, usually by injection but sometimes by mouth, e.g., oral polio. The process of altering the agent may result in its being killed, e.g., pertussis vaccine, T.A.B., or merely weakened though still alive, e.g., smallpox vaccine, Sabin polio vaccine. Sometimes the antigen is not the agent itself but merely a product of metabolism of the agent, e.g., diphtheria toxoid, tetanus toxoid. Immunity produced by this method requires a period of time to develop but is then long-lasting, requiring only periodic booster doses of antigen.

2. *Passive immunity:* This method involves the administration of preformed antibody derived either from an animal, e.g., diphtheria antitoxin, or another human, e.g., immune serum globulin. Antibodies from animals are obtained by administering the antigen and then bleeding the animal and refining the blood serum. The horse is commonly used for this purpose. Antibodies from other humans are obtained by refining the blood serum taken from convalescents, e.g., vaccinia immune globulin, or from adults who are presumed to have had the disease in childhood, e.g., anti-measles serum.

Passive immunity is effective within a few hours of the injection but the immunity is short, lasting only a few weeks. Furthermore, the use of blood serum derived from animals carries a high risk of serum reaction.

DISEASES UNDER CONTROL

It is instructive to examine how the application of the above methods have lead to the control of some of the greatest scourges of mankind.

Smallpox

This is a major infectious disease which for centuries decimated mankind in recurrent devastating epidemics. Up to the end of the eighteenth century, it was the most prevalent and dreaded disease. Scarcely five persons out of 100 escaped it and a quarter of those who contracted it, died. It has been controlled by raising host resistance by the mass use of a live attenuated antigen, the virus of vaccinia. From Jenner's initial observation that people who had had cowpox did not get smallpox, has developed modern calf lymph prepared by preserving, with glycerine, cowpox organisms which have been grown in the skin of the calf. It is introduced into the skin of the arm by a small scratch or multiple punctures. When a person is vaccinated he is being infected with a mild disease to protect him from a serious one. The initial vaccination or primary reaction causes the development of a pustule with surrounding inflammation on the ninth or tenth day after vaccination and this reaction may also occur in persons who have not been vaccinated for many years. Revaccination in most cases causes a modified reaction which may vary from simple redness and induration round the scratch at the third day, to a vesicle on the sixth.

Smallpox has been abolished in most Western countries but still exists in many other parts of the world. The introduction of a case may result in an outbreak here although careful screening of new arrivals from infected areas is carried out. If an outbreak did start in Canada, it would be dealt with by isolating patients in hospital using the technique described and tracing and vaccinating all contacts. Control of this disease implies total abolition—nothing else constitutes control.

Cholera

Control of this disease in western countries has come from application of the discovery by Snow that the disease is water-borne. Purification and control of public water supply has eradicated it and, as long as this control is continued, there is little fear of an extensive outbreak even if a case were introduced. The disease spreads by the fecal-oral route but this is only possible on a mass scale if a mass medium is involved. A vaccine does exist but it is a poor second-best and used only if sanitary precautions break down. The vaccine is a killed particulate antigen and it produces only limited immunity lasting about six months.

Cholera flourishes in many other parts of the world. Its natural home is around the delta of the Ganges in Northeast India. There, it smoulders in endemic form, making periodic and formidable forays in epidemic form. The last of these occurred in Egypt, in 1947, in association with the pilgrimage to the Islamic holy cities in Saudi Arabia and this was controlled by vac-

cine. A smaller outbreak occurred in Hong Kong in 1962 and a high endemic level has persisted in South East Asia since.

Diphtheria

This used to be one of the commonest causes of death in childhood but has been controlled by immunization. The diphtheria bacillus, when growing, develops a product of metabolism, a toxin, which is highly poisonous to man. Control has been obtained by immunizing children against the disease with an antigen prepared by treating the toxin with formalin. Canada was one of the first countries to use this preparation on a mass scale to obtain control of diphtheria.

Control depends on the maintenance of a high level of immunity among the child population. The routine immunization procedures are not now spectacular because of the absence of the disease; but control depends on their effective continuance. Outbreaks still occur in areas which have allowed their herd immunity level to drop.

Passive immunization in diphtheria is used only in the treatment of an actual case (where it may be life saving) and in the prophylactic treatment of contacts when it is combined with the first dose of the antigen in active immunization. For passive immunization, antitoxin which is prepared in the horse is used.

Poliomyelitis

While this disease has never quantitatively reached the proportions of the other great communicable diseases, it has probably caused more fear than any other disease in recent years. It many now be prevented by the use of two vaccines.

a. *Salk Vaccine* — a suspension of killed polio virus, given by injection.
b. *Sabin Vaccine* — an attenuated living vaccine, given by mouth.

The ideal arrangement is to give three doses of Salk vaccine during the first year of life and follow this with Sabin vaccine to give longer-lasting immunity. Using these methods, poliomyelitis has been reduced so that it now has nuisance value only and may soon disappear altogether.

Disease and the Rat

Two major epidemic diseases have their reservoir in the rat and are conveyed to man by means of an arthropod vector — the rat flea. The diseases are plague and murine typhus. Both are of great interest in the history of mankind and both have been controlled by reducing the rodent reservoir. Plague is still a serious problem in India and China where the third great world pandemic of recorded history is now drawing to a close. Under conditions of over-crowding and uncleanliness and, in particular, during famine and military campaigns, typhus may spread from person to person through the intermediary of the body louse. Many other fevers due to Rickettsia and related to typhus occur throughout the world. The Canadian brand is Rocky Mountain spotted fever in which infected ticks are both the reservoir and the vector.

Vaccines exist against both typhus and plague and are used to protect people exposed to risk; but control of the rat and the body louse are the most important preventive measures.

Yellow Fever

This is a virus infection spread from man to man by the Aedes egypti mosquito. Control of the mosquito by spraying and drainage has abolished the disease from North America. However, in South and Central America and in West Africa, jungle yellow fever exists in endemic form among the monkeys of the region and for the traveler in these regions yellow fever vaccine is used. This is a living attenuated virus prepared from the yellow fever virus. Great care is taken to prevent the introduction of the disease into India which has the mosquito but lacks the virus. Arrivals from the yellow fever endemic area are subject to rigid quarantine unless they have a valid certificate of inoculation.

DISEASES PARTIALLY CONTROLLED

Tuberculosis

The so-called "Great White Plague" still ranks with malaria and malnutrition as one of the three great public health problems on a world-wide scale. In western countries, however, a measure of control has been obtained

though it still ranks in incidence as a most important communicable disease.

In the past, control measures have been directed at eradication of the animal reservoir by eliminating tuberculin positive animals from dairy herds; rendering safe the environmental vehicle, milk, by pasteurization; isolation of the infected person and immunization of contacts with BCG. These measures were only partially successful, but the situation was transformed in the early 1950's by the discovery of the antimicrobial drugs, notably INH, PAS and streptomycin. We now have a weapon that can render an infected person non-infectious in a matter of weeks and offer a cure in months, in most cases. The preferred method is to attack the infectious agent in its known reservoir by chemotherapy and for this the reservoir must be identified. The unknown case constitutes the main problem and most health activities in tuberculosis now are directed at case finding, using the twin tools of the tuberculin test and the miniature X-ray. These methods are proving most effective and a promise of full control of the disease in western countries in the near future exists.

The situation is very different in tropical countries where the disease is still widespread. Control there rests on the development of adequate treatment facilities followed by case finding as treatment facilities become available.

Whooping cough (pertussis)

This is a major disease of childhood causing a great deal of distress in the older child and serious mortality in the first year of life. Some control is obtained by the use of a vaccine during infancy, but this vaccine has limitations. It is only partially effective and requires frequent booster doses. It often modifies the disease when it fails to prevent it, but it is unlikely that the vaccine will ever abolish whooping cough.

Typhoid

This is no longer a major problem, but smoulders in a low incidence endemic condition and occasionally develops into localized outbreaks. The endemic condition is usually associated with carriers who occasionally pass the disease on to neighboring persons. An outbreak occurs where such a carrier obtains access to a mass medium of distribution such as food, water or milk. Control of the disease involves excluding typhoid carriers from working as food handlers, the pasteurization of milk and proper control of water supply. Typhoid carriers are persons who have had the disease and still excrete the organism, so a disease outbreak always increases the number of carriers. Control of the major food and water-borne outbreaks reduces the number of carriers and should, ultimately, eradicate the disease.

DISEASES NOT CONTROLLED

Viral hepatitis

This really consists of two diseases, namely infectious hepatitis (I.H.) and serum hepatitis (S.H.). These are identical clinically but different epidemiologically. The reservoir of I.H. consists of human cases of the disease and spread is by the fecal-oral route; the reservoir of S.H. is the blood of healthy persons and spread involves infecting the blood of one person with virus from the blood of another. The administration of blood and blood products, inadequate sterilization of needle and syringe, use of multiple injection syringes, drug addiction, tattooing, have all been factors.

A proper technique for sterilization and the use of disposable syringes and needles, are effective safeguards against S.H. but any administration of blood and blood products carries a calculated risk — although this risk is clearly over-ridden in many cases by the value of the administered blood. Proper hand washing after defecation, isolation of the patient and control of food and water are the best safeguards against I.H.; since the virus has now been grown in artificial culture, a vaccine may also soon be forthcoming.

Salmonellosis

This is caused by a large variety of organisms which have their reservoir in human cases and carriers and a variety of animal foods, of which turkey and dried egg are common ones. Control of this probably lies in more effective control of the animal reservoir, by proper cooking of turkeys and

avoidance of use of dried egg products for mass catering. The numerous incidents of food poisoning provide the human cases and carriers from which spread occurs to other humans by the fecal-oral route.

Venereal Disease

Syphilis and gonorrhea are much less severe now owing to the effectiveness of treatment by penicillin. The recent increase in the incidence of these diseases, particularly among young persons, gives serious cause for concern from a social and moral point of view. Clearly, there are undesirable factors in the social and emotional components of the modern environment which require considerable attention from health and social workers.

Measles

This is a serious disease of childhood occurring in epidemics every two years. The development of vaccines brings the possibility of control into view. In the present state of their development, the vaccines can only be safely and effectively used in individual cases. Further refinement will be required before using them on a mass scale.

LET'S LOOK AT SCHOOL HEALTH SERVICES

ALICE BEATTIE, B.S.

As public health nurses, are we realizing our potential in school health services? Before we can answer this question, we must ask ourselves others: Is evaluation a continuing part of our work? Are we ready to forsake unproductive routines and move forward into challenging areas of service that demand professional competence? Do we use auxiliary workers to advantage? If we can answer these questions in the affirmative, we have taken a long step toward giving positive, effective public health nursing service to the school age child.

There are many reasons for giving particular attention to evaluation and planning in the school health program. This is a service to children at a time when they are likely to respond well to educational, preventive or remedial health measures. The potential returns are high. We must also keep in mind that the school health service absorbs a greater proportion of the public nurse's time than any other program. It may encroach on time required for the over-all community health service. From the teaching point of view it often cuts into time allotted for the school curriculum. For all of these reasons, continuing evaluation is essential.

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School health services must be viewed in their true perspective as one link in a chain of continuous health care that starts in the prenatal period and is continued in a series of programs throughout childhood into old age. Approximately 22 per cent of the population attend school for some 200 days a year and for less than a third of each day. Because of the special needs of school children and the fact that they are at a strategic age to benefit from care, it seems reasonable for nurses to spend more than 20 per cent, but not more than 30-35 per cent of total community nursing time in the school health program.

In the British Columbia Health Branch, public health nurses in 18 health units provide a generalized public health nursing service. They have school case loads of approximately 1000 pupils. The service is offered in

both public and private schools. These schools range in size from the one-room rural school to the urban secondary school with 1200 or more pupils. Visits are planned with the school principals and are made on a regular basis. The small outlying schools are visited about once a month; those with several hundred pupils about once a week; the larger schools, two or three times a week. Non-professional recording is done by the health unit clerical staff; nursing equipment and supplies are maintained by health unit aides. Volunteers are used to a limited extent to assist with clinics for immunization and tuberculosis testing.

In 1961, a committee of Health Branch personnel was set up to review the existing school health program. This committee subsequently made recommendations incorporating the views of the Department of Education. In April, 1962, a revised program was adopted jointly by the Health Branch and the Department of Education. The program was to be subjected to intensive study for two years and then considered for revision. This paper is, therefore, in the nature of an interim report. Further changes are anticipated before September, 1965.

RECOMMENDED SCHOOL HEALTH PROGRAM

In the recommended program, the respective roles of health and education personnel are defined. With a view to more effective use of time, certain routine activities are replaced by selective procedures. Emphasis is laid on methods by which pupils with special problems are identified. These include vision, hearing and tuberculin tests, teacher-nurse conferences, and school liaison committee meetings. Certain aspects of the program that are likely to be of particular interest have been selected for comment.

Responsibilities of Teaching Staff

The nurse meets with the principal at the beginning of the school year to discuss the program and to make plans for the coming months. The principal then arranges for the nurse to attend a staff meeting so that she may interpret the program to the teachers and invite their cooperation. Teachers are not asked to undertake duties that require training in the field of public health. They are expected to give assistance commensurate with their training and responsibilities. In addition to the teacher's commonly-accepted responsibilities for health instruction, daily observation of pupils, and minor first aid, she has been encouraged to become increasingly involved as a member of the health team in working with pupils who have special problems. No one can use to better advantage an understanding of the needs of the diabetic or the epileptic child, or be in a more strategic position to provide the day-to-day support required by the child who is emotionally disturbed.

Teacher-nurse Conferences

In these planned conferences, which are held in elementary schools with each teacher individually, information and expert knowledge are shared for the benefit of the child. The nurse contributes from her knowledge of the pupil's health history and the family situation; the teacher, from daily observation of the pupil. From this sharing of information, pupils can be selected for special follow-up which may include referral to the school medical officer or family physician.

In secondary schools the procedure is flexible but provision is made for planned conferences that permit discussion of any pupil who has a special problem. In addition, secondary schools may form "liaison committees" composed of the principal, counsellors and the public health nurse. The social worker, probation officer and other community resource personnel are invited as required. Pertinent information regarding selected pupils is exchanged; a course of action proposed. One or more members of the committee may be able to give the required help or, in some cases, referral to a special service such as the mental health clinic may be necessary.

Medical Examinations

Examinations by the school medical officer are on the basis of referral from the nurse. Children with special physical or emotional problems are brought to the nurse's attention in many ways, such as conferences with

teachers, a review of family records or personal observation. The nurse screens these pupils before referring them to the school medical officer. She also refers children who have no apparent problems but are unlikely to receive supervision from a family physician due to financial circumstances, family attitude or geographic location. Under this latter provision, all grade one pupils in an outlying school or all pupils in a small isolated school may be examined. Parents are encouraged to be present at the examination. If this is not possible, the nurse obtains a medical history from the family before examination.

Ideally, every child should be under the health supervision of the family physician from birth through childhood and adolescence. In many areas, health units, with the cooperation of the local medical society, have been able to encourage examination by the family physician prior to school entrance. The physician uses a special form to report to the health unit, noting in particular any physical or emotional problems that may affect the child's progress or his activities at school.

Vision Tests

Vision screening is performed by the nurse for children in kindergarten, special classes and grades 1, 2, 4, 6 and 8, using a Snellen Chart in an illuminated box. In grade 10 where the arrangement of classes calls for special planning, an effective method has been the "blitz" in which one period is set aside for teachers to screen pupils in all grade 10 classes simultaneously. The teachers use a Vision Screening Card for Teachers with letters that correspond with the 20/20 and 20/30 lines on the Snellen Chart. All who fail to read the 20/30 line are referred to the nurse. In other grades, the nurse rechecks pupils whose vision was borderline in the preceding year. Other pupils are tested at the request of a teacher, a parent or the pupil himself. The nurse checks to be sure that children who wear glasses are receiving the recommended care but they are not included in screening tests. Ishihara charts are available for testing pupils suspected of being color-blind.

Hearing Tests

In grade one the nurse tests the hearing of each child using a portable transistor unit (15 and 35 decibels at 2,000 and 4,000 frequencies) and retests with a standard audiometer as indicated. In other grades she tests any child who appears to have a speech or hearing defect. Children with 15 decibels or more of hearing loss in frequencies of 500-4,000 are referred to the family physician. The nurse discusses these pupils with the teacher so that appropriate action may be taken such as seating the child near the front of the room.

Tests for Tuberculosis

School children are given tuberculin tests routinely in grade 2. Positive reactors receive periodic chest x-rays; other members of the family receive tuberculin tests and further investigation as indicated. At intervals of approximately five years, children in all grades have an opportunity to be tuberculin-tested as part of a community-wide survey.

Boards of school trustees have given enthusiastic support to the recommendation that all personnel employed by a board should be examined for tuberculosis. The initial examination consists of a tuberculin test. If the result is negative, the test is repeated in two years; if positive, a chest x-ray is performed immediately and repeated a year later, then every two years.

Weighing and Measuring

Children are not weighed and measured routinely. The nurse periodically checks those for whom surveillance of the growth pattern is indicated, for example, those obviously under- or overweight.

Home Visits

Basic to the public health nursing service, and one of its greatest strengths, is the home visit. It enables the nurse to gain insight into the family situation and provides an opportunity for health counselling in the home setting. Visits are made when children have come to the nurse's attention because of some particular problem. Visiting is not carried out routinely for absenteeism but school personnel at-

tempt to discover the cause of recurrent or prolonged absence and notify the nurse if the health of the pupil is involved.

Immunization

As a result of an active immunization program in the pre-school years, immunization at school is essentially a maintenance program. In 1962, over 60 per cent of children were completely up-to-date on entry to grade 1. The few children who have not had a series of quadruple antigen (diphtheria, pertussis, tetanus and poliomyelitis) are offered the series in grade 1. Reinforcing doses are given, if necessary, as well as smallpox vaccination. In grades 5, 9 and 12, re-vaccinations are performed, and reinforcing doses of the triple antigen are given (omitting pertussis vaccine).

An immunization consent card is signed by a parent, usually in the pre-school period. The consent remains valid throughout the school years.

Health Records

A health record is initiated for children at birth and used throughout life. This record is kept in the "family folder" along with other health records of the family. For children who have a special problem such as epilepsy, diabetes, a heart condition or severe emotional disturbance, the nurse initiates a special disability card in a distinctive color. This record is kept in the permanent school record so that it will alert the teacher early in the school year to potential problems. Health records are the responsibility of the health unit staff and are maintained by them.

Procedure in Accidents or Illness

The provision of emergency care for pupils is the responsibility of the school. Health unit personnel provide a list of necessary first aid supplies and a guide for first aid procedures. Through consultation they assist the principal to develop plans for dealing with accidents or sudden illness but it is not considered their function to provide an emergency service.

Participation in Physical Activities

Pupils normally participate in the physical education program unless they present to the teacher a written request for non-participation. Recurrent requests to be excused are referred to the nurse. Physical examinations are not performed routinely for pupils who will be taking part in competitive sport.

Health Teaching

Public health nurses act as resource persons in health teaching. They provide teaching aids, such as a dental kit; white rats for teaching nutrition; pamphlets, posters and films for special projects such as health education in relation to smoking. They assist in planning activities related to health, such as Junior Red Cross and Future Nurses' Clubs. They may also encourage appropriate health instruction to relate to some particular situation in the school or community. Health unit personnel are not qualified for classroom teaching. This must remain the responsibility of the teacher. The nurses have, however, in close cooperation with the schools, developed a program on menstruation which includes films and talks to girls and their mothers. Health units are now promoting a program of sex eduction for boys that promises to be well accepted.

Kindergartens

The kindergarten setting provides an opportunity for observation of the child at a crucial stage in his development. By planned conferences and informal discussion, nurse and teacher can consider each child with particular reference to his family situation, early development and group adjustment. These children are provided follow-up care by the nurse in the usual way. They are referred to the school medical health officer for examination as indicated. Vision testing is performed routinely. Children respond more readily to the tests toward the end of the kindergarten year than they do early in grade 1. At the present time studies are being conducted to determine the feasibility of routine audiometric screening.

The Mentally Retarded and Handicapped

Nurses make regular visits to the

schools for the mentally retarded. They often find that these children have multiple problems and require extra time and attention. In addition, many children with special problems are now included in the regular school system. They may have handicaps such as cerebral palsy, hearing loss or a crippling condition from injury or illness. The nurse must use initiative and ingenuity in assisting school personnel to meet the individual needs of these children.

CONTINUING EVALUATION

As part of the evaluation of the recommended school health program the 18 health units of the B.C. Health Branch have conducted studies in the past two years. Although some reports are still pending, certain changes in the program have already resulted. Perhaps more important, the studies have brought about a changing concept in which the health program for the school child is seen as having its beginning not in grade 1, but in kindergarten and nursery school. Indeed, interest has been evoked in introducing screening procedures at a stage when they will be of greatest value, for example, testing in early infancy for evidence of deafness or strabismus.

Changes to date have resulted in a program that is practical, effective and well accepted by nurses and teachers. Continued evaluation will undoubtedly result in still further modification to meet changing concepts of service to the school-age child.

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Community Mental Health Services

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The care of the patient involves his mental, as well as his physical health.

A regional mental health clinic, the objective of the various communities in the Okanagan over a period of several years, became a reality in November, 1962. The appointment of a psychiatrist, social worker, psychologist and stenographer, with headquarters in Kelowna, initiated the new venture. Prior to this, the area had been served by a travelling clinic that visited for a week twice yearly. Frequent changes in personnel, both in the clinic and the various agencies in the area, resulted in lack of continuity in the follow-up of cases. Patients needing hospital treatment were admitted to mental institutions at the coast. They left family and friends and were lost in the world of the large hospital, a situation that often contributed to poor adjustment following discharge.

An addition to the South Okanagan health unit provided the accommodation for the mental health team. The area serves a total of three health units — measures 35,000 square miles and has a population of 150,000 persons. About 70,000 of these people live in four equal-sized cities that are 300 road miles and one hour's air travel from Vancouver.

Along with the establishment of the regional mental health centre, the Kelowna General Hospital Board established a psychiatric unit of seven beds in the hospital. The service offered by this unit was on a regional basis. It was soon found that more than half of the patients being admitted were from centres outside Kelowna. The control of admissions to the unit lies entirely with the clinic psychiatrist.

The smooth operation of the clinic

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depends upon close cooperation between all professional staff in the community — family physician, social workers, probation officers, special school personnel, public health nurses, etc.

A Citizens' Advisory Committee was established under the Union Board of Health. It receives quarterly reports and discusses needs for further development of the service. It is felt that each major city in the region requires its own citizens' group. A committee with representatives from the various professions was set up to act in an advisory capacity to the Citizens' Committee.

Scheduling of cases for the Mental Health Clinic varies from district to district within the region. In Kelowna, welfare and probation representatives have definite appointment times; the public health nurses and special school counsellor share the same days. Overlapping of service is avoided by interchange of information by the agencies when indicated. In every case an attempt is made to encourage the participation of the family physician.

In the other areas visited, all professional groups share the same day. A screening committee has been set up in each centre. Participants vary according to the local situation. Cases are reviewed and selected on a priority basis for presentation to the clinic. The schedule provides time for assessment of new cases, both adult and children, and of patients who are being carried on treatment. Time is also scheduled for consultation with the professional workers. The local branch of the Canadian Mental Health Association provides volunteers for a sustaining clinic that is held once monthly in the larger centres. This clinic, under the supervision of the mental health team, provides an opportunity for patients to socialize while waiting to see their therapist.

The demand for service has been high and more time is required. However, since a resident psychiatrist has recently joined the staff, plans for an increase in service are now underway.

The public health nurse in a mental health program is in a unique position because of her close association with the home and the school. It is in these areas that the opportunity arises to observe family relationships, to identify crisis situations and, when indicated, to motivate those concerned to seek professional help. Frequently, she acts as the liaison between the family and the various professional agencies in the community. It is her responsibility to know the functions of these groups and to be able to interpret them to the family. While it is apparent that the work of the various agencies overlaps to some degree, each has its own special function and each can contribute to the solution of the problem. Because the public health nurse often knows the family best she may be requested to continue the contact and prepare a social history prior to the patient's appointment with the clinic. The follow-up of the case is not always her responsibility. The clinic decides which agency is better qualified to carry out its recommendations. The nurse, in carrying her own cases, receives assistance in their management from the members of the mental health team. This lessens frustration of her efforts to assist some of her distressed families.

On occasion, patients discharged from the psychiatric ward of the Kelowna General Hospital are referred to the nurse for follow-up in the home. Contact is maintained with the clinic by the submission of periodic progress reports.

The functions of the public health nurse are important and necessary in her relationship to the Mental Health Centre. However, the field of prevention remains her forte. Preventive techniques are applicable throughout all phases of her generalized public health program from prenatal care to supervision of the geriatric patient.

Summary

The establishment of a regional mental health clinic with its service integrated with those of the health unit is meeting a long-felt community need. It is now possible for the mentally ill to be hospitalized in the area and receive continued follow-up care in the home by the professional staff of the various agencies. With the availability of the psychiatric team for guidance these workers are able to cope more

adequately with the problems encountered in their caseloads. At the same time, however, the realization of our lack of background knowledge in the field of mental illness makes us aware of the necessity for continuing inservice education. A start on this has already been made by the psychiatric team.

Before the public health nurse can function effectively as a member of the mental health team, it will be necessary to reduce her caseload to the point where she will have sufficient time to cope with the mental health problems in her area as well as time to give anticipatory guidance, especially in maternal and child care. Research studies would point to the areas where this could be achieved.

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LEARNING THROUGH PLAY

ANN GIBSON

It would seem that the more civilized and automated we become, the more need there is for parent education in this area.

The operation of child health centres has been an established activity of most public health departments for a good many years. In the Greater Vancouver Metropolitan area, the program is under constant review to see whether the services offered are still meeting the needs of the thousands of "clients" who attend each year. Staff are encouraged to experiment with new and different approaches in the centres and to devise projects which will help meet the needs of various areas.

In the project described, the author was assisted by other nurses attending the centre as well as by the supervisor and medical officer. The psychiatrist and the psychologist attached to the health unit not only offered many constructive ideas on the project itself, but proved that theories on child development can be demonstrated in a very practical way.

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Philosophy and Purpose

This play demonstration project has been a wonderfully stimulating and rewarding experience; stimulating, because it required thought and effort which resulted in a personal learning experience, rewarding, because very definite results can be seen in some of the parents' attitudes towards play and the development of their child. The aim of the project was to provide an informal setting where the child plays and the mother observes. This is where learning takes place for all concerned:

The child is perfecting a new skill while playing; the mother is learning to observe more subtle signs of development and what equipment the child needs at each phase; the nurse is learning about the child, the mother and their relationship.

I will start with the premise that these early years are exciting and fascinating. Through exercising his five senses, the child explores and discovers the dimensions of his world. Through his experiences, he will learn his identity, his role, to work out fears and problems, and to form the foundation on which he builds the rest of his life. Nothing can compare with the activity, eagerness and spirit of adventure of young children working towards a goal. In order that they may attain their goals they must have the proper experiences and equipment — play and toys.

Too often in the home, the mother is tired, irritable or bored. She doesn't seem to really see or enjoy her preschooler. The child is often whiny and frustrated with nothing to do, or tearing the house apart because he has no suitable, constructive activity offered him. Then we see the child starting kindergarten and school where, too often, he is not ready for this more formal learning situation because of the lack of a good foundation. If the trend continues, it follows the child into adulthood.

Some of these children are referred to the mental hygiene clinic where we see a parade of troubled children and their parents. Regardless of the basic reasons for their problems the one area of therapy that is usually recommended is *play*. Play is recommended to improve child-parent relationships, to help deal with aggressions, to help an inhibited child blossom, to help a child with role identification. The wonderful thing is that play and its results can be so easily demonstrated. Parents who cannot communicate and understand on a verbal level can gain some understanding when a concrete demonstration is given.

In all these areas and many others we find, time and again, that many parents do not understand the importance of play in child development. It would seem that the more civilized and automated we become, the more need there is for parent education in this area. Most primitive tribes are acutely aware of teaching their children through play. The child wants to learn to be like his parent and learns this role through imitative play. It is for this reason, according to many authorities, that one-year-olds often refuse to play with hollow boxes and want to play with pots and pans like "mommy."

Fun with play dough

Through participation in our Preschool Mental Hygiene Clinic, I acquired an understanding of the use of play in assisting with various problems and personally saw and experienced the outcome. One family, in particular, was most revealing. There were multiple factors involved, including marital problems. The parents were not ready to make any changes in their own relationship but were ready to consider their two preschoolers' need for play. They followed through on play recommendations and demonstrations made both at the clinic and at home. This, of course, did not solve all problems but it did dramatically alleviate some of the children's problems. They were allowed to work out their concerns through play and were given one constructive area to grow in even though relationships in the home remained strained.

In the child health centres, I found many mothers unable to grasp anticipatory guidance in this field. I noticed that when one could point out develop-

mental phases evidenced by another child present at the clinic, a mother was able to grasp the meaning of development better. Too often the setting of the child health centre lacked the opportunity to really illustrate the development of a child, e.g., a curious two-year-old exploring everything in sight. In many cases when play things were mentioned the mother immediately thought of "bought" toys. Demonstration seemed the best way to show a mother that simple objects often make the best toys.

I have tried to carry over to the child health centre play setting the wonderful feeling of a child's growth and development and his need to try out his developing skills. If one can project to the parents the excitement and wonder of a child's evolvement the rest will naturally follow.

Setting up the Project

The project was started in one of the child health centres in September, 1963. After almost a year of trial and error and learning, the demonstration is starting to fulfil its stated purpose. We had no guiding articles or books oriented to this rather unique situation and, therefore, we have had to adapt and modify plans.

Preliminary Considerations

The factors we considered in setting up the plan were:

1. *Available space:* We had to rearrange the child health centre several times to find the most suitable arrangements. In this I include storage space, the lack of which can limit materials used.

2. *Ages of children:* This determined the materials to be used.

3. *Available time:* A few parents now plan their time at the child health centre to permit their child to play; some stay as long as an hour.

4. *Community served:* This community is a low income, labor class of many different backgrounds. Language and cultural background are influential factors, e.g., many Italians use all the yard space for a vegetable garden, leaving only the streets for the children to play in.

5. *Community play areas:* In our situation, there were only school grounds and a small park. The latter was too far away for most people.

6. *Materials to be used:* This is affected by preceding factors. So far we have tried to limit materials and toys to those that are readily made or available in most homes. One reason is financial but many more reasons enter into it. For example, a child can be more creative and imaginative with simple, "raw" materials.

7. *Play area supervisor:* In this case it is the public health nurse. She must understand the whole concept of play and be willing to study and learn how to operate best in this situation. Volunteers should not be expected to fulfil this role.

8. *Public health nurses staffing the centre:* The ultimate success lies with the "conferencing" public health nurse. The mother has to be prepared if she is to get the most out of the demonstration. Where this has been done we have had some very excellent results.

Materials Used

I will not try to itemize or list all the toys made, materials supplied and plans that have been used at the child health centre. Suffice to say that many toys have been made and materials assembled that have had to be thrown out because they were not suitable. Everything has to be given a good trial though, because what one group of children ignore, another group will find fascinating. Safe toys must be used. A toy that may be safe for an older preschooler may not be for the toddler.

Role of Public Health Nurse

I encourage the child to enter into a play activity. When he is playing I discuss his play with the mother. Quite often the conferencing nurse will accompany the mother to point out a specific point they have been discussing. Many mothers are reluctant to get involved. Generally, if one can get the child busy at something, he will involve his mother despite her reluctance. For instance, a little toddler took a great liking to a sock doll and took it to her mother to admire. The rather remote and insecure mother came over to me and asked how it was made. It turned out that her little girl had a life-sized, porcelain type of doll at home but didn't like it. This led into what type of dolls and accessories children like at certain ages.

The mother learned quite a bit about development in this area in a very informal way. She has been back four times so far and the last time stayed almost an hour to let the child play. I heard her telling another mother to let her little girl help dust.

Another mother of a four-year-old boy didn't even want to sit in the play area and instead, sat out in the hall. In the meantime, I helped the boy with a very simple jigsaw puzzle. At first he had no idea how to put it together, then progressed to where he was able to. The next visit he cut out and pasted, and although he was very awkward he ended with a passable finished piece of work to take home with him. Later, the mother approached me and said, "I didn't know he could do all them things. Hubby and I went out and got him a puzzle, scissors and paste." I haven't seen them since but I think the mother views her son with more respect now.

Another thing I have learned is to go very slowly with both mother and child. A classic example would be a mother with her only child, a five-year-old son. She practically breathed for him and he was glued to her side. Finally, after watching the other children, he decided to cut out and paste, with mother sitting beside him. She corrected him continually. I was pondering how I could get her away from him when another mother came along with two girls, sat down and let the girls choose what to do. They immediately started to paint, making a wonderful mess. Their mother watched with interest but did not interfere. I noticed the first mother taking all this in, then she went and sat with this second mother, watched and did not interfer again. Her son forgot about her and spontaneously went over to paint with the girls.

Often one unintentionally demonstrates something. Two fathers were sitting watching the children play. One had a two-year-old son who kept interfering with the older children. The father yanked the child away and scolded him but the child immediately started back to the older group. Automatically, I distracted the child with something else and he played quite happily. The one father said to the other: "See, that's the way to handle them." This was my cue to join them for a minute and talk about what the little boy liked to play with and what to expect of him.

Learning with blocks

This setting is very good for the "competitive" mother who is constantly comparing her child to another. A mother complains that "my one-year-old is not walking and the one-year-old over there is." Generally, you can find some area where her child is advanced more than another. In this case, her child had better eye-hand control in putting objects into a container. Better yet, though, in a few cases where the child has come regularly, I can point out to the mother what new skill the child has perfected. She could not do such and such last time but she can do it this time. Gradually, these mothers stop comparing their child to others and compare the child with himself.

Then there is the mother who constantly underestimates her child's ability and does not encourage him to try anything new. A little boy attempts to pin a cloth on the clothesline. The mother says he can't do that yet but is deterred from interfering. He finally masters the clothes pin and everyone smiles in great triumph.

Not All is Rosy

It may sound as though everything fits into place and runs smoothly all the time. This, of course, is untrue. Some days are chaotic and it seems that not one constructive event has

taken place. It might be well to list some of the pitfalls:

1. Many adults tend to interfere too much in a child's play. If he is floundering completely, it is wise to help him get started but it is not wise to jump in or object if he even looks as if he is thinking about doing something with a toy. If left alone he may come up with a unique idea. I have noticed that once a child's trend of play is broken by an adult he often will not go back to it. One three-year-old was happily occupied with "play dough" until I decided to show him how to use the rolling pin. He decided he didn't want to handle it and left the table.

2. I often become so engrossed in getting the children started on special projects, e.g., if they want to paint, getting them gowned, etc., that I forget all about the parents.

3. I constantly have to check myself about giving *regular lectures* regarding development and play in answer to a simple, specific question from a parent. I have found that, on the whole, it works best to keep remarks related to whatever the child is doing. A child puts his hand in and out of a container, tries to drink from it, turns it upside down and shakes it. This is the time to speak to a mother about a child learning the concepts "full" and "empty."

4. Another "danger spot" is in the area of reprimanding a mother. A mother spanks a toddler for pushing over another child's tower of blocks. It is unwise at this point to interfere. I am becoming more alert to catching these situations before they arise. I sometimes build a tower for the child and remark to the mother that children seem to have to learn to knock things down before they learn to build them up. Then, when the toddler knocks down the tower, the mother may come over and help him build up another one to knock down.

These are just a few pitfalls one has to watch. By being aware of what you are trying to accomplish, they can be avoided.

It is worth mentioning that the toys I have made for this clinic are quite crude because of my lack of craftmanship. This has turned out to be an asset. Mothers have said, in a roundabout way, that they are going to make a doll but that they will make it in a different and better way. Fathers have good naturedly laughed at my attempts to make a train and implied that they can make a better one. A child may come to me and say that his dad made a wagon that is much superior to mine. I think that this situation is very good because it gives the parents a recognized field of superiority. If play materials are too well made, parents might feel they are too hard to make.

Some Results

The only way one can measure how much parents and children are getting out of this is by their reactions.

Three little girls brought their father to clinic. He stated he had to come and see for himself since the children talked so much about it. He examined the wagon and doll carriage very carefully so that he could make the same at home.

Mothers are reporting that they don't have to struggle to get the children to come to the clinic any more, rather that the children want to come. Apparently, "getting a needle" is overshadowed by the play setting.

Parents are beginning to bring me play ideas. I feel this indicates that parents are thinking more about play. They are participating in the program.

Another mother reported that she now felt happy children were more important than a clean house. She had always shied away from such things as "play dough" because of the mess.

Other mothers come and report how well a child can do something since working in the play centre, for example, cut with scissors.

At one session, I had two-page booklets made of scrap material for the children to paste pictures in and take home. Two mothers reported to me that the children liked the pictures so much that they bought them picture books. These children were three and four years old and had never had a book.

The children will happily come and tell me when anything is duplicated at home. One of the proudest children was one who reported that he now possessed painted tin cans like mine.

These remarks, made to me and to other nurses, make us feel that the concept of play is slowly being accepted. All of us are becoming more skilful and, therefore, we hope that the idea will continue to grow.

Providing Continuity of Care

CHRISTINE E. CHARTER, B.S., *and* ELIZABETH BRANCH

After thirty years of experience with referral systems, hospitals and visiting nurse services are still looking for the answer to the question: What will become of this patient when it is time for him to leave hospital?

Constructive provision for continuity of nursing care through referral plans continues to appear in many places as an aim to be achieved, rather than as an established pattern of service. Although real accomplishments have been made, too often one hears of patients whose progress is hindered, who are readmitted to hospital and who, with their families, experience unnecessary apprehension and worry simply because suitable arrangements for continuing services have not been made at the right time — before the patient left the institution.

In Vancouver, as in many other centres, the Victorian Order of Nurses, as one community agency, has been working with hospital staffs through liaison services to alter these situations. Gradually, more people — professional, patients, and families — are realizing the advantages of pre-discharge planning which permits health and welfare agencies to care for people in their homes according to their present needs.

In these programs a Victorian Order nurse is on duty in the hospital for varying periods of from two to three hours per week to full time, depending on the local situation. The liaison nurse must be familiar with the hospital policies and practices as well as those of community health and welfare groups used for the referral of patients for further care. An understanding of people and ability in the communicative skills are also valuable qualifications for this position. Some of her duties, in a well-organized program, include the following:*

1. Planning with the medical, nursing and social work team for care of patients who require further attention on discharge;
2. daily contact with wards and clinics;
3. visiting patients scheduled for home nursing visits;
4. arranging, if necessary, for visits to the home for assessment of the total environment, including the ability and willingness of the family to provide the care required between the nurse's visits;
5. constant communication with the V.O.N. and other agencies used for referral: the Metropolitan Health Committee, Canadian Arthritis and Rheumatism Society, D.V.A., the Multiple Sclerosis and the Cancer Societies, the Canadian Paraplegic Association, the Children's Aid, etc.;
6. incidental conferences with doctors, nurses, social workers, physio and occupational therapists concerning patients' needs;
7. responsibility for the mechanics of transmitting referrals and follow-up reports;
8. orientation of the hospital staff to the program and of the V.O.N. staff to the hospital set-up;
9. participation in the education of students concerning the referral system;
10. participation in in-service programs both in the hospital and the community.

Borrowing from V.O.N. experience in other areas, the program in Vancouver has developed until, in 1963, over 1,000 patients were referred through liaison service to community care. From a small beginning in the medical and surgical wards, patients are now also referred from obstetrical,

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* V.O.N. for Canada, *Information for Initiating a Hospital Referral Program*, Aug., 1961.

psychiatric, activation wards, public and private, and from out-patient departments.

We have discovered that hospital personnel sometimes seem to consider it a reflection on their care and teaching if a patient needs further service on discharge. We hasten to say that this is not the case, but that the behavior of many patients and of members of their families is quite different outside the hospital, in their own surroundings. Lack of self-confidence and anxiety frequently interfere with the remembrance and performance of procedures which are apparently well-understood while in hospital. Situations involving colostomy care, dressings, multiple medications, dietary problems, discharge after long-term hospitalization, crutch-walking at the non-weight bearing stage, and care of a baby or child are some of the anxiety-provoking areas that may be relieved by even one or two home visits by the visiting nurse, particularly when older people are involved.

The liaison services have proved to be of direct value, also, to the professional personnel involved in the patient's care. The family doctor helps the patient and family plan for the continuing medical care needed; but it is becoming virtually impossible for him to obtain readily, from widely scattered sources, the information required to plan the best patient care that is available outside the hospital. The supervisor and head nurse are also key persons who must be aware of the role of other groups in relation to patient needs. They have a responsibility to doctors, to patients and to the public to let them know what community services are available and how they may be used to the best advantage by the patient and family. The liaison nurse can help to provide this necessary information, as well as that relating to the patient's home, family, culture, and religion. Because she has access, if necessary, to various hospital departments: medical records, pharmacy, dietary, physical medicine, she is able to pass on to the nurse entering the home a fairly complete picture of the patient's needs and of his hospitalization, all of which should result in improved performance. If the hospital has an out-patient department, the Victorian Order nurse sends a report back to the hospital before the patient's clinic date. Follow up from the clinic to the V.O.N. and vice versa continues as long as necessary. We find that hospital directives and reports contribute to better care in the home, while the doctors and nurses in the clinics get a clearer understanding of the patient's adjustment at home. A return report is sent to the hospital when a patient is discharged by the V.O.N. If he is being carried over a long period, a report is sent every two or three months, and this is filed with his permanent hospital record.

When we first attempted to plan for continuity of care we soon became more aware of the gaps in community services. This has resulted in the establishment, by the V.O.N., of a male visiting nursing program; of physiotherapy consultant and service program for those patients unable to attend rehabilitation centres or clinics; and of a housekeeper service in North and West Vancouver. The recent addition to the V.O.N. staff of a public health nurse who is also a certified physical and occupational therapist opens another way of contributing to the continuity of experiences started in the hospital setting, and the maintaining of skills and abilities in those patients unable to attend rehabilitation centres, or between visits to them. These services have also resulted in more hospital beds being freed, and in increased co-operation with the community groups mentioned previously.

As nurses, whether male or female, in the hospital or out-side it, our chief concern is the patient. We appreciate the cooperation we receive and we hope that by continuing to work and plan together we can help the patient reach the limit of his capabilities and know that at least it was not because of poor planning or lack of imagination that recovery was not as complete and rapid as possible, or that a family did not get help when it was most needed.

Perhaps each of us should give some thought to the questions: *"How does this concern me as a nurse, as a citizen? Is there something I could or should be doing to close some of the gaps in service in my own area?"*

A DESIGN FOR HOME CARE

LAVINIA M. CRANE, B.S.N., M.P.H.

Home care may range in scope from the simple and uncomplicated provision of medical and nursing service in the home to a complex of skilled services coordinated to meet the patient's total needs.

The term "home care" has become very popular during the last decade and has caused some confusion in its definition. Home care may be a hospital-based program, it may be conducted by a public health or visiting nurse agency or it may be established by a particular society or association for care in a certain specialized field. Any organized home care program should, however, be a component part of a total community health plan.

Three essential characteristics are:

1. Centralized responsibility for the administration and coordination of services;
2. some plan for the provision and coordination of such services;
3. a multi-disciplinary team approach in the planning for and provision of services.

The philosophy of home care is not new. The Boston Dispensary, as early as 1796, established such a service to provide medical care to the poor. The Victorian Order of Nurses did pioneer work in this field in Canada beginning in 1897. In British Columbia, it began with the home nursing service which was part of the public health nurse's work in Canada's first health unit, established in Saanich in 1921. As health units developed, public health programs changed and home nursing care was given only on a demonstration or short-term basis. The need for care in the home appeared to decrease as hospital care became more readily available.

Later, changing times and conditions again emphasized the need for home care. In 1947, an attempt was made to reinstate a home nursing care service in the public health program in British Columbia. The South Okanagan Health Unit started a special project in home nursing care in conjunction with a locally organized and financed housekeeping service. In 1951, the North Okanagan Health Unit, in cooperation with the Vernon Jubilee Hospital, set up a second project to determine whether hospital patients could be discharged earlier and still receive adequate care in their homes.

Following the success of these two pilot projects, the Health Branch of the British Columbia Department of Health, set up a pattern of home care as part of health unit service. Once again the Saanich and South Vancouver Island Health Unit led the way. In 1954, utilizing the experience of the two study projects and the Department's plan for organization, a home care program was established as part of their generalized public health program.

Various questions and problems arose in the planning of such a service. Should the official health agency in each area sponsor and administer the home care program? Was it possible to design a program which could be equally effective in the urban, heavily populated area of Saanich and in the small town of Williams Lake with its surrounding rural area? Not only did we want a coordination of services within each community and health unit but we wanted a coordination and a uniformity of services throughout the province. Were the resources, available in rural areas with scattered populations, sufficient to supply a multiplicity of services to patients located there? Could a basic plan be designed so that a simple home care program could be set up immediately in any area and then expanded as more local facilities and resources became available? Would it be possible to provide extra public health nursing staff so that existing programs and services would not be reduced? How would the

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cost of financing this service be arranged? What would be the criteria for acceptance of patients to the home care program?

Certain strengths which would simplify organization of the program in the province were also evident. Generalized public health services in all these areas were provided by local health units under the jurisdiction of the Provincial Health Branch. Although program emphasis varied according to the needs of the particular health unit, a standardization of policies, procedures and records was in effect throughout the area covered by provincial health services. A similar organization existed within the Provincial Department of Social Welfare and a generalized program of services was provided by social workers. Already a close working relationship had been established between these two groups.

A good liaison existed between hospitals, private physicians and public health personnel. The health unit directors participated in medical staff meetings and public health nurses made routine visits to hospitals in connection with their pre-and postnatal programs.

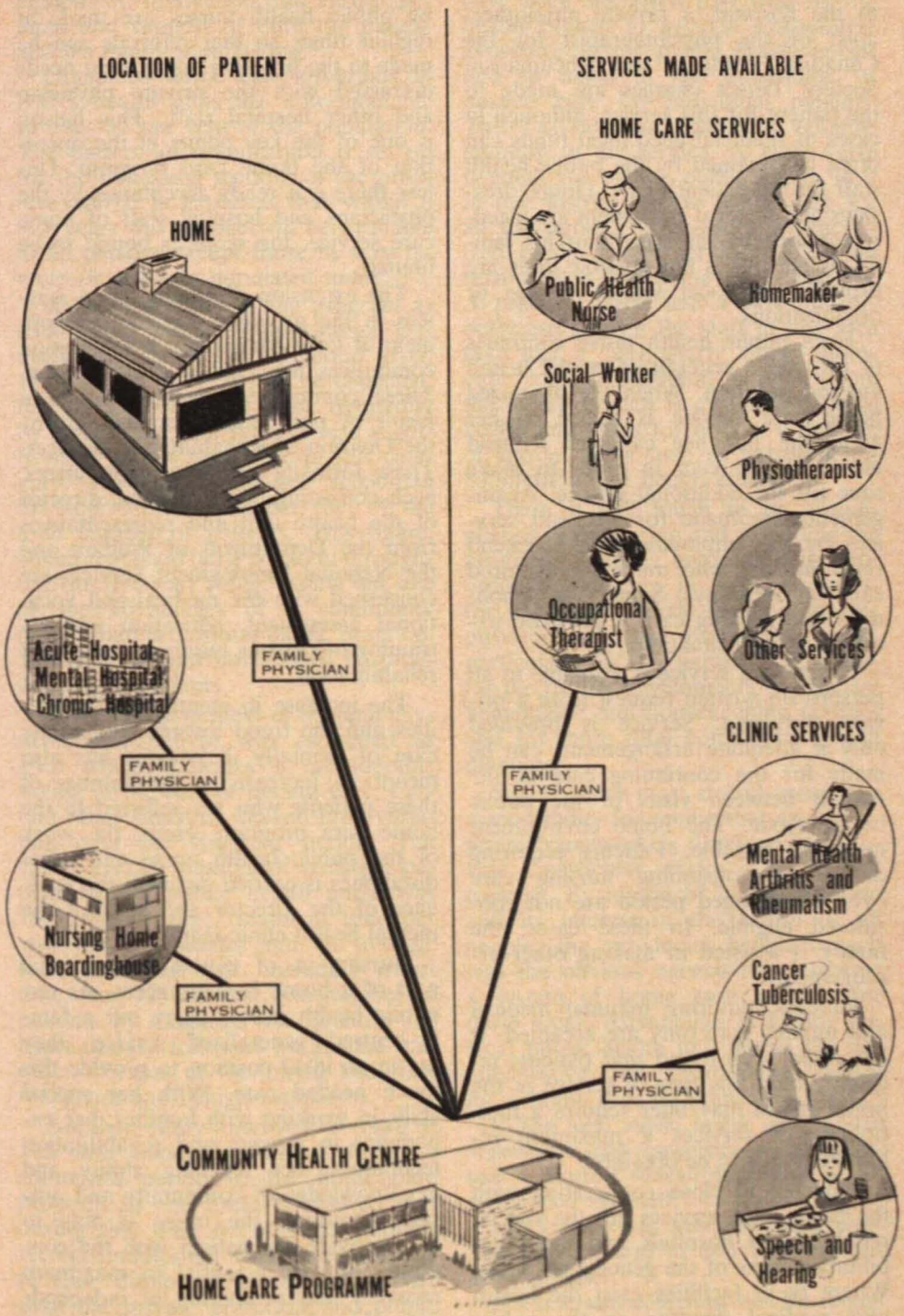
Voluntary health organizations and public health staff worked closely together. The community health centre building was, in most areas, the meeting place for the various societies. Public health personnel and members of the voluntary groups, were aware of their programs and plans and were already active in coordinating their work in the community.

Arrangements for visits of special consultative and diagnostic clinics were made by the local health unit and facilities and accommodation were, in most cases, provided for them in the health centre. The regular clinics included the Tuberculosis Diagnostic, the Cancer Consultative Clinic, the Mental Health Clinic, the Vancouver Children's Hospital Travelling Clinic, the Speech and Hearing Clinic and the Arthritic and Rheumatism Consultative Service.

With these questions, problems and strengths in mind, plans to provide home care services in those districts of the province outside metropolitan Vancouver and Victoria were considered. In those two areas, public health and home nursing services were provided by the municipal health departments and the VON and a close liaison with them was maintained.

The basic design of the health department home care program is simple. In providing services, the local health unit acts as the administering and coordinating body. The majority of patients are referred directly by private physicians. Each referral is reviewed by the nursing supervisor and the medical director and a decision regarding acceptance to the program is made. A social worker, physiotherapist or other professional person may also be involved in this decision. Once a referral is accepted for the program, the public health nurse works closely with the private physician under whose instructions the patient care is given. Referrals to other disciplines and to existing community services are arranged by the public health nurse or medical director following discussion with the physician concerning the patients' needs. The public health nursing supervisor or person in charge of the program in the health unit is responsible for coordinating the plans for care and for regular review. For the patient discharged from a rehabilitation hospital or the activation unit of a general hospital, the referral to the home care program is made following review by the hospital Case Review Committee.

Organized home care programs are made available through the local health units on request from local municipal representatives. If such service is desired in unorganized territory, the request must come from a representative group, preferably a ratepayers' association and a local area must be set up by the Department of Municipal Affairs. When the service is implemented, the municipality or area concerned is assessed on the basis of 10 cents per capita as a contribution toward the cost of providing this service. As the service is tax-supported, no charges are made for the nursing or social work services or for consultative services provided through provincial funds or any of the voluntary agencies. Consultative advice regarding the physiotherapy requirements of the patient is available in most communities through hospital or clinic physiotherapists as is


LOCATION OF PATIENT
SERVICES MADE AVAILABLE
HOME CARE SERVICES
HOME
Public Health Nurse
Homemaker
Social Worker
Physiotherapist
Occupational Therapist
Other Services
Acute Hospital
Mental Hospital
Chronic Hospital
FAMILY PHYSICIAN
FAMILY PHYSICIAN
FAMILY PHYSICIAN
CLINIC SERVICES
Mental Health
Arthritis and Rheumatism
Nursing Home
Boardinghouse
FAMILY PHYSICIAN
Cancer
Tuberculosis
FAMILY PHYSICIAN
COMMUNITY HEALTH CENTRE
Speech and Hearing
HOME CARE PROGRAMME

help to the public health nurses in supervising the activity regime of the patient. For actual physical therapy treatment, however, the patient is referred to the hospital, a private physiotherapist or the physiotherapist for the Canadian Arthritic and Rheumatism Society. Direct charges are made to the patient for this service, although in cases of financial need local funds can often be obtained by the public health staff for the patient's care. Drugs, dressings and medical equipment are usually supplied by the patient or his family. When this is not possible, they are provided by local service groups or organizations.

Each public health nurse continues to provide a generalized public health nursing program. When the organized home care service is added to her area, she has her caseload reduced about 25 per cent in order to make time for the additional service. Arrangements are made for weekend services by the employment of "weekend relief nurses" who make the required calls on Saturdays, Sundays and holidays. No evening care is provided except in special situations.

Home care service is available to all persons on written request from a private physician. Service is provided only if adequate arrangements can be made for the continuing care of the patient between visits of the public health nurse. The home environment must be suitable. Patients requiring daily, time-consuming nursing care over a prolonged period are not considered eligible. In these cases, the family is assisted in making other arrangements.

Patients requiring minimal medical and nursing care only are accepted. It has often been found that patients requiring only this type of service in the initial stages may later require a multiplicity of services if maximum rehabilitation is to be obtained.

Working in close cooperation with the home care services are the special rehabilitation hospitals and the rehabilitation units of the general hospitals. Where these facilities exist the health unit medical director or the public health nursing supervisor serves as a member of the Case Review Committee and assists in the screening of patients for discharge and for home care follow-up. In all communities, close liaison with the general hospitals is maintained and visits to the hospital by public health nurses are made at regular times so that referrals can be made to the program and patient needs discussed with the private physician and other hospital staff. This liaison is one of the key points in the operation of the home care program. Unless there is a ready acceptance by the physicians and hospital staff of home care service, the scope is bound to be limited.

The extension of rehabilitation services in the province and the development of local community rehabilitation committees has been a decided asset. These committees have evolved as a result of past studies carried out by the Division of Rehabilitative Services. These formally structured committees, each consisting of the medical director of the health unit and representatives from the Department of Welfare and the National Employment Service, are concerned with the medical and vocational assessment, education and retraining of persons requiring vocational rehabilitation.

The increase in mental health facilities and the trend toward community care of mentally ill persons has also meant an increase in the number of these patients who are referred to the home care program. Here, the work of the public health nurse and other disciplines is carried out with the guidance of the director and staff of the mental health clinic team.

Nursing is, of course, an essential part of a home care program. As our public health nurses carry out a family-centred generalized service, they are in an ideal position to provide this much needed care. With her special skills in working with families, her experience in nursing and rehabilitation techniques, her teaching ability and her knowledge of community and outside resources, the nurse is able to help provide the patient with the continuity of care essential to maximum recovery and promotion of independence. In addition to general nursing procedures, such as injections, catheterizations, dressing of wounds, and colostomy irrigations, she is concerned

with range of motion exercises, self-care activities, nursing assessments, improvisation and adaptation of home equipment, motivation and encouragement and support of both the patient and his family in adjusting.

Organized home care programs in B.C.'s health units are now available to over 51 per cent of the population. The pattern of organization is set up for the remaining sections of the province and it is expected that within a few years this service will be available to all persons except those in very remote or sparsely populated areas.

A detailed study of the program as it involved public health nurses was made over a five-year period from 1959 to 1963. As would be expected, the service was used most frequently by persons over 60 years of age; slightly over 71 per cent were in this category. Hospital discharges accounted for approximately 30 per cent of the total number of patients. This figure, which remained fairly constant throughout the five-year study, points out one of the advantages of a community rather than a hospital-based program. The latter would cover only hospital-discharged patients.

The average number of hospital days saved per patient was estimated as 14.0 which indicates a considerable saving in the cost of patient care. Certain other statistics showed little variation over the five-year period. The yearly average number of visits per patient by the public health nurse was 19.5; the average treatment time per visit was 21 minutes and the average total time per visit, including travel time, was 32 minutes. The number of patients by diagnosis was greatest for heart disease followed by anemia and other diseases of the blood and then malignant and benign neoplasms.

Another study involved a total of 195 new patients admitted during a six-month period to the home care program in one area. It showed that during this time 67 of these patients received additional assistance from one to four disciplines or agencies other than the private physician and public health nurse. If each of these patients had been followed for the full length of time on the service or for a six-month period, this figure would no doubt have been considerably higher.

In the more populated areas where the program is heavy, physiotherapists have been employed part time by the health branch to provide consultative assistance to the public health nurses and to assist in the assessment of needed care for individual patients. This has been an extremely valuable addition to the service. A male nurse is employed on the public health staff in one district but, as is the case for all the nurses, he provides a generalized public health service and is not restricted to the home care program. A practical nurse and a part-time orderly are also on the staff in one area that has a particularly heavy home care load. Consultant service from the health branch is available to local health unit staffs for help in a number of special areas such as nutrition, rehabilitation and health education.

There is still much to be accomplished in improving and extending the program. There is need for better co-ordination of care in some instances, for improved referral systems, for the provision of more professional staff, particularly in the paramedical fields, for the further development of efficient homemaker and housekeeping services and for more total community health planning.

Some agency must always accept the responsibility for seeing that an appropriate framework is developed to provide a particular service in its area of concern. By reason of its organization and its interest in the health of all people, the provincial health branch was the obvious agency for designing a system of home care suitable for those areas. Advantages in having the local public health unit act as the administrative and coordinating centre for a home care program are:

1. The local public health unit has the organization and experience to administer such a program without duplication of administration and staff.

2. It is concerned with community problems and is geared to deal with most aspects of these.

3. It is already concerned with the coordinating of health services to eliminate duplication of facilities and program and to promote a comprehensive community health plan.

4. A close working liaison has been established with hospitals, physicians, voluntary health societies and other government and community agencies and the health unit building is the centre of many community health activities.

5. The public health staff is already providing a generalized, family-centred public health service to all persons in the community regardless of age, social or economic status. A home care program fits logically into this service as the needs of the home care patient cannot be isolated from those of other family members.

6. The health unit director as the medical director of the home care administration, the community rehabilitation committee and as a member of the hospital activation ward case review committee and a number of other boards is in an ideal position to guide the planning for continuity of patient care in the community.

7. The services of most special clinics, e.g. tuberculosis clinic, cancer clinic, are made available and arrangements for referral to these clinics are made through the health unit offices.

8. Because of uniformity in the program throughout the province, a patient discharged from a hospital in Vancouver can be referred for follow-up to the program in Prince George, 500 miles away. Similarly, a patient from Dawson Creek while visiting in Kelowna will readily fit into the program there.

Summary

There is frequent discussion, both verbal and written, concerning home care programs and the need to provide a complex of coordinated services concerned with the total needs of the patient. It is often inferred that such a program cannot be effective without a separate formal administrative organization to plan, assess and coordinate the services of the required multi-disciplinary team. From experience dating back to 1954, it is my belief that such a comprehensive program can be organized and work well in any area where a local public health agency is providing a good generalized public health program and where a minimum of other services including a physician, a social worker and access to hospital care exist. It is quite true that an ideal organization would have readily available to it all social services, occupational and physical therapists, nutritionists, housekeeping and homemaker services, vocational guidance workers, meals-on-wheels and so on. It does not seem reasonable, however, to wait for all these facilities and services to be developed before commencing a modified home care program. Many areas will never have them. Nevertheless, a great variety of resources is available in every community regardless of size if we really look for them.

Numerous pilot projects have pointed out the value of home care in the community. It is now time for us to reinstate home care in the public health program and along with other basic programs to evaluate, improve and extend it as quickly as possible.

In the Good Old Days

(*The Canadian Nurse* — NOVEMBER 1924)

Future students of medicine and nursing are sure to grumble at the inappropriateness of having a Schick test for diphtheria and a Dick test for scarlet fever. That is supposing, of course, that the new test reported by Doctors George F. Dick and Gladys Amy Dick of Chicago turns out to be a genuine discovery. Certainly the evidence in its favor is very strong.

* * *

Many who have given the matter serious study feel that the present system of nurse education still leaves a great deal to be desired. The major need throughout Canada is for qualified nurse instructors on the staff of the training schools. This request comes from hospitals large and small.

The problem to be solved is how to induce nurses to enter the teaching field. For some years, the need of nurses in the public health field has been much emphasized, and nurses have qualified themselves for this branch of work, with the result that this need is now being met with far greater success than the need in the training schools.

If this outstanding need in the majority of schools could be stressed at meetings of every nursing organization affiliated with the CNA, one feels confident that the solution would be forthcoming.

Public Health Nursing in the Nursing Curriculum

RUTH M. MORRISON, M.A.

A description of a program in operation.

At the University of British Columbia there are three channels through which public health nurses are prepared for practice. These are: the basic degree (four years beyond first year university, or its equivalent); the post-basic degree (approximately three years beyond graduation from a hospital school); the diploma (approximately nine months for the graduate nurse who does not intend to proceed to a degree).

I have chosen to confine my remarks to the basic degree program since this is the one in which we can work with students during their entire nursing preparation. However, I would like to point out that, to the best of our ability, we help those enrolled in the postbasic degree program to attain the same level of preparation. They receive the same degree (B.S.N.) at the completion of their program.

Before entering the school students must have successfully completed courses in English, an approved elective in the humanities, mathematics, chemistry and zoology. These form a basis of scientific principles.

Curriculum planning begins with a statement of philosophy and purpose upon which program objectives are based. Objectives must be realizable in terms of time, clinical resources, staff and other limitations. It must be recognized that students cannot attain the full measure of all desirable qualities by the time of graduation, but that a foundation will have been laid on which they will continue to build.

We believe that graduates with a B.S.N. from this university should have achieved:

1. Sufficient general education to enable them to grow in understanding of the society in which they live and to participate intelligently in efforts to promote the welfare of society;

2. ability to work effectively with people, both individually and in groups;

3. ability to communicate effectively with the people they serve and with other professional groups, and to organize and express their thoughts clearly both orally and in writing;

4. understanding of principles that are fundamental to the practice of nursing, and ability to utilize them in the adaptation of methods and techniques;

5. sufficient skill in the performance of nursing techniques and procedures to enable them to give a good quality of care to patients;

6. ability to recognize and deal constructively with nursing problems that they will encounter in the course of their professional activities;

7. understanding of basic principles of learning and teaching, and ability to plan and carry through effective teaching of individuals and groups;

8. a beginning understanding of the elements of curriculum construction, and an awareness of the responsibilities and functions of junior members of a nursing school faculty;

9. understanding of the basic principles of administration and ability to apply them at a level commensurate with their competency;

10. understanding of the modern concept of supervision; ability to seek and benefit from supervision; ability to apply supervisory skills and techniques at a level commensurate with their competency;

11. an awareness of the variety of community resources for the care of the sick, prevention of illness and the promotion of health, and of the role of the nurse in helping people to benefit from these resources;

Miss Morrison is a professor in the school of nursing, University of British Columbia.

12. some understanding of the roles of various members of the health team, and some skill in working effectively as a nurse member of the team;

13. an awareness of and ability to utilize resources that will enable them as they increase their experience, to continue to grow in knowledge, understanding and skill as professional nurses;

14. an appreciation of the evolution of nursing and the nursing profession, and of their individual and group responsibilities for helping to further the continued development of both.

These achievements are surely appropriate to public health nursing practice.

We were anxious that the students should have learning opportunities in public health early in their program. What we have achieved in this regard is not ideal, chiefly for two reasons. The clinical areas and the university are approximately six miles apart; we have had a shortage of instructors. However, all of the clinical instructors have had public health preparation and several have had agency experience. In a few years time the UBC Health Sciences Centre will provide additional facilities, and the ratio of clinical instructors to students is gradually improving.

In planning the nursing curriculum, five assumptions, which serve as guide posts for instruction, have evolved.

1. All human beings have basic needs.

2. Certain factors will influence the extent to which the individual is able to meet each basic human need.

3. Certain sources of data can be used to assess the ability of the individual to meet each of his needs.

4. If he is unable to meet a basic need, a nursing problem results.

5. With the nursing problem defined, the nurse uses her personal and professional resources to plan the approach to solve the problem.

We have defined basic needs as exercise, rest, sleep, oxygen, food and water, elimination, protection from environment, coordination of body processes, affection, achievement, security, relationship, and sexual activity. The influencing factors for each and the observations that the students should make regarding each are considered. In addition, instructors approach the planning of learning experiences from the standpoint that the patient is a member of a family; his illness affects the whole family; the family is part of the rehabilitative team.

Since I will refer to courses by name or number, and in order to give the reader a concept of the total program, a condensed version of the course offerings during the four years the students are in the School is listed below. "N" refers to nursing courses.

First Year

Bacteriology 200
Chemistry 210
Psychology 100 (or an elective)
N. 155 Anatomy and physiology
N. 156 Introduction to nursing
N. 157 Orientation to nursing in hospital
N. 167 Introduction to the nursing profession

Second Year

Sociology 200
N. 250 Human growth and development I
N. 263 Public health nursing I
N. 290 Medical nursing I
N. 291 Surgical nursing I
N. 292 Obstetric nursing I
N. 294 Pediatric nursing I
N. 296 Psychiatric nursing

Third Year

English 200
Sociology 301
N. 363 Public health nursing II
N. 390 Medical nursing II
N. 391 Surgical nursing II
N. 392 Obstetric nursing II
N. 394 Pediatric nursing II
N. 395 Nursing team leadership

Fourth Year

Sociology 315 or 320
N. 450 Human growth and development II
N. 454 Preventive medicine
N. 456 Nursing III
N. 458 Teaching
N. 460 Administration
N. 463 Public health nursing III
N. 467 The nursing profession
N. 483 Field work
N. 485 Nursing study

In anatomy and physiology (N. 155) the instructor (a nurse well-qualified in this area) directs the students' thinking to the positive and preventive aspects of health in relation to the structure and functioning of the human body.

In the introduction to nursing (N. 156) the students select a cultural group for particular study to become

familiar with patterns of living and special religious observances including dietary habits. In working out procedures from principles involved they begin with the normal person's health needs including nutrition and progress to the more exacting needs related to the effects of illness.

Nursing 157 is taught entirely in the clinical areas. It may be regarded as a continuation of N. 156. It is here that the students strengthen attitudes towards the importance of the family in the patient's recovery process, begin to identify nursing problems, and work toward their solution.

The public health implications of bacteriology, chemistry and psychology are obvious as they are also in the sociology courses in the second, third, and fourth years.

In obstetric nursing (N. 292) and pediatric nursing (N. 294), the public health focus is on the family's and the nurse's role in helping to achieve family-centred care. Prior to junior clinical experience in the obstetric and pediatric departments, the common core of instruction consists of about 18 hours related to the emotional aspects of pregnancy; societal and personal attitudes toward pregnancy, childbearing and motherhood; maternal deprivation; characteristics of the newborn; breast and bottle feeding and other aspects. Attention is directed to the emotional responses of the family to labor and the adjustments that must be made in the postpartum period. A capsule presentation of the content of prenatal classes is given with emphasis on their application to the management of labor; the importance, significance and methods of teaching the patient and the family; the participation of community agencies in mother and child care.

In senior obstetrics (N. 392) consideration is given to methods of family planning and the nurse's role; the principles of managing emergency delivery; the emotional and social problems faced by unwed mothers, including the legal and social aspects of adoption. During this rotation students spend approximately 20 hours in the office of either a general practitioner or an obstetrician where they gain an understanding of the importance of the physician's role in the maternal cycle.

In pediatric nursing (N. 294 and N. 394) emphasis is placed on certain aspects of health supervision and the part that the nurse can play, such as assisting with the health appraisal of the child; teaching concepts of safety and their application; teaching parents postoperative home care, and the supervision of the child with a long illness. Continuity of care through the use of community agencies is encouraged. To this end students spend a week with a child care centre that operates a nursery school and a foster home day-care program.

In medical-surgical nursing (N. 290, 291, 390, and 391) the family unit is not lost sight of but, quite naturally, the patients suffering from a long-term or permanent disability or handicap present the greatest opportunity for the introduction of public health aspects of nursing — particularly the need for teaching patients and families.

In addition to the experience gained in the acute general hospital, students spend a total of 45 hours in hospitals and agencies where they can observe the team process in relation to prevention and rehabilitation. Patients suffering from tuberculosis, poliomyelitis, cancer, strokes, arthritis, industrial accidents and other disease entities and conditions are the concern of these hospitals and agencies. Nine weeks are spent in the study of psychiatric nursing (N. 296). This experience and instruction is built upon previous learning opportunities, notably human growth and development I, which includes interpersonal relationships. The students learn of the whole spectrum of mental health services available to patients on a referral basis and of the relationships of other public health and welfare services to the mental health services. This is an area of study in which they become acutely aware of the need for the public health nurse to be psychiatrically oriented. Those who later practise public health nursing draw upon the knowledge acquired here to a tremendous extent.

The instruction and experience in team leadership (N. 395), helps the future public health nurse to assess patients' nursing needs; establish

priorities; record accurately and fully; evaluate results; appreciate the importance of other members of the health team and the value of scheduled conferences; gain some understanding of the principles of supervision and administration.

One of the advantages of a degree program that includes public health nursing preparation is that it can be spread over the whole learning period. So far I have spoken of how it infiltrates courses that are not wholly germane to public health nursing. The courses entitled "public health nursing" are specifically directed to public health nursing practice. In the second year in N. 263 the philosophy, development and organization of health and welfare services are considered. Basic instruction in common communicable diseases is given. In the third year, N. 363 deals with the scope and nature of public health nursing including intra- and inter-agency relationships, public health education, citizen participation, and the basic concepts of disaster nursing. Included also is one week's experience in a hospital emergency department, and three weeks with the Victorian Order of Nurses. In the fourth year, N. 463 increases the students' understanding of the scope and nature of public health nursing with particular emphasis on family health guidance in homes, schools, clinics, classes and places of work. The management aspects of public health nursing are considered. Collateral knowledge essential to practice, such as public health nutrition and statistics, is included. Public health nursing field work (N. 483a and b) consists of 20 hours of observation and participation in a child health program which is multidisciplinary in nature; approximately 60 hours in the care of the handicapped; five weeks of experience in generalized public health nursing in a public health agency.

Preventive medicine (N. 454) is important in any area of nursing and is, of course, essential to those engaged in public health nursing. The epidemiological approach to the control of disease (communicable and non-communicable, acute and chronic) and to the promotion of health, the fundamentals of environmental sanitation and of food control are basic to the work of all practitioners in the health field.

Public health nurses must, along with all nurses, participate in the support of their profession and its associations and be aware of the patterns, trends and problems of nursing education. Courses N. 167 in the first year and N. 467 in the fourth year are designed to prepare them for these responsibilities and privileges.

Recently, I heard someone comment in a radio interview that our present knowledge of communications in relation to what we may some day know is comparable to what was known in the Stone Age about tools. Perhaps this is so. Certainly, we know that the public health nurse must develop all the skill that she possibly can in communicating with people. To a great extent her success depends upon it. While the courses that emphasize communications most are human growth and development I and II and psychiatric nursing, this area is not lost sight of in other classes and in the daily contact with students in the clinical areas.

Nursing study (N. 485) presents an opportunity to investigate fully some aspect of nursing in which the student has particular interest, and which she herself selects in consultation with the faculty. Here, she draws upon much of what she has learned in courses in English, methodology and statistics, her clinical experiences and other sources. A great many studies are related wholly or in part to public health nursing though some students select a topic that is otherwise oriented. Whatever subject is selected, carrying it through to a satisfactory completion in the form of a written presentation will inevitably help the nurse should she enter the field of public health nursing either permanently or temporarily during her career.

An introduction to the fundamentals of curriculum construction, which is an important part of teaching, is included in N. 458. This course builds on earlier instruction and experience in teaching. It synthesizes knowledge of the principles and planning related to the teaching of patients, nursing personnel and nursing students. The public health nurse spends a great deal of

her time in teaching (one of the forms of communication) and the principles apply in all situations. The students are required to plan for the teaching of a selected unit of clinical nursing to a particular group of students. The situation is not entirely hypothetical since the fieldwork in teaching (N. 483c) is four weeks' experience in the actual teaching of first-year students in their N. 157 course, under the guidance of a faculty member. Each senior student is responsible for the instruction and supervision of ward practice of three or four students. For the graduate who plans to work in a public health agency this preparation and experience is a tremendous help in teaching patients in their homes; conducting classes in the community; acting as a field guide to students; orienting new staff members. Earlier in the final year, the students also receive instruction in the teaching of expectant parents, including prenatal exercices.

Since every nurse at every level and in all settings is to some extent an administrator, the course in administration (N. 460) which deals with the fundamentals of administration and their application in nursing services is of intrinsic value to the future public health nurse.

All educators are aware that the curriculum of their school is never static. It must constantly change to meet the social and economic needs of the times. All would agree that it is a struggle to keep up with newer knowledge of content and method. There is no thought of achieving perfection, but excellence is the elusive goal of education. Teachers of nurses, like other teachers, are continually striving to attain this goal. In a school of nursing which offers a generic program the faculty must select learning experiences that will ensure that its graduates can utilize their learning in both hospital nursing and public health nursing, resulting in a narrowing of the gap between sickness and wellness. It is a challenge which cannot be taken lightly. No university can meet it without the active help and support of its community hospitals and agencies. In this respect, we are fortunate indeed at the University of British Columbia.

NEW PROBLEMS with an OLD DISEASE

JOHN H. SMITH, M.B., B.CH., D.P.H.

Syphilis, the great ravager of nations, has once again returned to our midst.

Through the centuries, syphilis has killed millions of persons and crippled many millions more. The arrival of penicillin, in the early 1940's, brought with it dramatic changes and was certainly a break-through in the treatment of this disease. Syphilis dropped from a 1947 high of more than 100,000 reported cases in the United States to a low of 6,516 cases in 1955. However, according to the U.S. Public Health Service, there were over 20,000 new cases of infectious syphilis *reported* last year. This is not all the cases that occurred. As recent studies have shown, many private physicians reported only about half their diagnosed cases and, in some areas, much less than this. Reliable estimates indicate that infectious syphilis (reported and unreported) occurred in the U.S. at a rate of between 80 and 100 thousand cases during 1962.

At the World Forum on Syphilis, held in Washington, D.C., in December, 1962, many of the 33 other countries which furnished data gave reports of rapid increases in veneral disease. Britain, for example, has had a 73 per cent increase since 1958 and France a 147 per cent increase since 1957. A global study undertaken by the World

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Health Organization revealed an increase of infectious syphilis in many regions of the world for the period 1957-60.*

Syphilis has increased in both sexes, in all age groups, races, and social groups and in every area of the U.S. Canada, which showed a rapid decline with the introduction of penicillin, has also had a sharp increase since 1958. This increase has occurred in spite of a high standard of living and the absence of war.

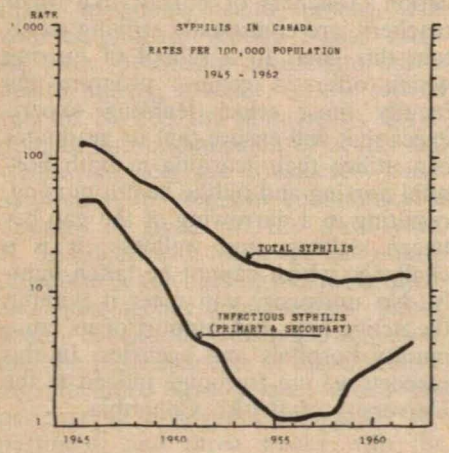

Fig. 1

The infectious syphilis rate shows a more rapid decline which ended in 1955; however, the rate has risen sharply since 1958. *The infectious syphilis rate is a more sensitive index of trends than the total syphilis rate.*

Table 1 shows that while rates for total syphilis have shown a slight increase since 1958, the rates of infectious syphilis (recent infections) have more than trebled from 1.2 to 4.2 per 100,000 of the population.

In British Columbia, infectious syphilis has been increasing since 1956. At that time, the level of eradication had almost been reached, with only 11 cases reported for the whole province. This increase has been especially rapid during the last two years:

1961 — 64 cases were reported.

1962 — 183 cases were reported, representing a 188 per cent increase.

1963 — 282 cases were reported, representing a 35 per cent increase over 1962, and an increase of *330 per cent over the 1961 figure.*

Age Group of Cases

In the U.S., where increases have occurred in all races and age groups, the greatest percentage increase was among the young. Teen-age infections are apparently becoming more and more of a problem.

In Canada, however, as in British Columbia, the increases in syphilis have occurred mainly among young

* T. Guthe and O. Idsoe, *Venereal Diseases and Treponematoses: Nature, Extent and Significance,* World Health Organization/VDT/300, Oct. 19, 1962.

TABLE I

TOTAL AND INFECTIOUS SYPHILIS

CANADA 1958-62

	Total Syphilis		Infecious Syphilis (Primary and Secondary)		Infectious Syphilis (Primary and Secondary)
Year	Cases	Rates per 100,000 pop.	Cases	Rates per 100,000 pop.	Cases as per cent of Total
1958	2038	12.0	205	1.2	10.1
1959	2144	12.3	389	2.2	18.1
1960	2168	12.2	461	2.6	21.3
1961	2311	12.7	587	3.2	25.4
1962	2432	13.1	783	4.2	32.2

adults of 20-35 years and in males more frequently than females, a ratio of four or five to one (Fig. 2).

Causes of Increase

One is often asked why this tremendous increase has occurred, especially as far as infectious syphilis is concerned. Many reasons are believed to be responsible for the increase. These have been stated by various authorities.

Following World War II, venereal disease rates increased all over the country. The population, as a whole, was alerted to the danger and this helped to bring about early detection. Penicillin began to be widely used and the toll of infectious syphilis was rapidly reduced. Since penicillin had widespread use for other ailments, such as sore throats, staphylococcal infections, etc., many cases of early syphilis were probably treated unknowingly and aborted.

Around 1955-56, the number of cases of infectious syphilis had reached a low level and it was felt that eradication of the disease was imminent. Public health authorities and physicians were perhaps lulled into a false sense of security. Along with this, budgets for venereal disease programs were markedly reduced — particularly in the U.S.

Instruction in the prevention and treatment of venereal diseases disappeared from the curriculum of medical and nursing schools, since clinical material was lacking. Also, about the same time, physicians were becoming more aware of sensitivity reactions to penicillin and this particular antibiotic was being treated with respect and certainly not being used for minor infections to the same extent as previously.

These various factors, along with the fact that certain organisms, particularly *Neisseria gonorrhoea,* had developed resistance to the recommended doses of penicillin used for treatment, contributed, no doubt, to the resurgence of venereal disease.

Many social changes have taken place. In fact, a social revolution almost certainly has occurred during the past decade. Although it may have started slowly, it has gained momentum during the last five years. Society has become less concerned, either through ignorance or complacency, about such things as venereal disease.

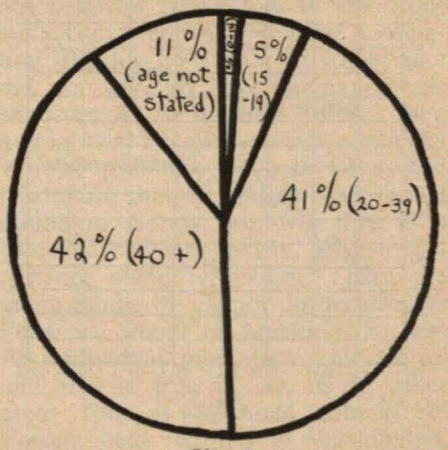

Fig. 2

Relative contribution made by various age groups to the total number of syphilis cases reported in 1962.

In a recent sociological study of 600 teen-agers attending social hygiene clinics in New York City, only 10 per cent possessed what was rated a good understanding, i.e. that venereal disease may be contacted through both homosexual and heterosexual relations; that gonorrhea and syphilis are different diseases and that they are not transmitted through public drinking cups, toilet seats or towels.** Promiscuity has increased and this would certainly appear to be a prime reason for the increase in venereal disease. An indication of this increase in promiscuity can be obtained from illegitimate birth rate statistics for British Columbia (Fig. 3).

These indiscriminate sexual relationships have increased partly because the puritanical influence, a long time moral force in our community, has been diminishing. The fear of pregnancy is no longer a deterrent. Younger people are financially independent, have few responsibilities, and are continually seeking new excitement. The wider

** C. S. Deschine, *Teen-agers and Venereal Disease. A sociological study of 600 teen-agers in New York City Social Hygiene Clinics.* U.S. Department of Health, Education and Welfare, Communicable Disease Centre, Venereal Disease Branch, Atlanta, Georgia, 1961.

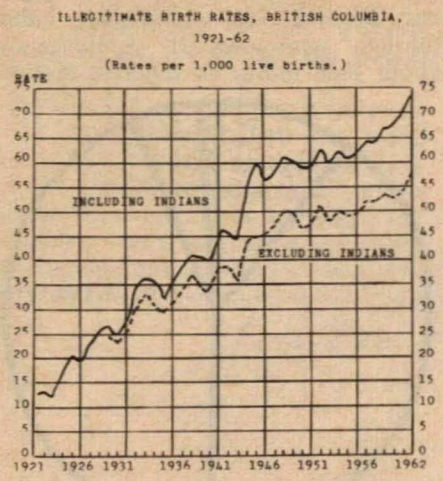
ILLEGITIMATE BIRTH RATES, BRITISH COLUMBIA, 1921-62
(Rates per 1,000 live births.)
RATE
INCLUDING INDIANS
EXCLUDING INDIANS
1921 1926 1931 1936 1941 1946 1951 1956 1962

Fig. 3

use of the automobile permits people to travel to other communities far removed from the watchful eyes of their friends and neighbors; and this provides them with the opportunities for intimacy. The automobile has become "the motel room on wheels." Sexual stimulation is being provided at an unprecedented level by films, television, books and magazines and the young people of this day and age are being bombarded with sex information of every kind. One does not have to mention the various magazines that appear on the newstand; it is obvious that nothing is left to the imagination. Also, various novels that would have been banned a few decades ago are now being hailed as classics and are being widely read.

The female has become more and more idolized as the sex symbol. Every effort is being directed towards increasing this in a variety of ways, e.g. the female dress, or probably more correctly the lack of it. The more seductive the designs, the better they sell!

Apparently, teen-age sex clubs exist in many places, even in high schools. If a person brings venereal disease into one of these groups, epidemics can certainly result.

Psychologists and church leaders have made conflicting statements about sexual relations, adding to the confusion of the situation. Often, adults are inclined to blame the adolescent and teen-ager for the problems they are now facing. But is it not society which is, in fact, responsible for allowing such things as the sale of pornographic magazines and the showing of sex movies both in the theatre and on television? All these and many other sexually-stimulating devices could be forbidden, or better controlled, if enough people felt strongly about the matter.

Bishop Gerald Kennedy, of Los Angeles, states the situation as far as that city is concerned: "The atmosphere is wide open. There is more promiscuity

TABLE 2

ILLEGITIMATE BIRTHS BY AGE OF MOTHER

(Excluding Indians),

BRITISH COLUMBIA, 1956-62

Year	Age Group								Total	Rate per 1,000 Live Birth
	Under 15	15-19 Years	20-24 Years	25-29 Years	30-34 Years	35-39 Years	40-44 Years	45 and Over		
1956	12	464	453	327	245	132	38	2	1,673	48.7
1957	13	561	539	359	243	130	38	4	1,887	51.4
1958	17	593	547	351	216	151	52	1	1,928	51.4
1959	15	643	602	304	238	155	48	4	2,009	53.1
1960	23	621	588	342	214	147	48	2	1,985	52.4
1961	16	633	597	296	228	135	37	3	1,945	53.6
1962	16	638	619	349	235	164	41	2	2,064	57.7

and it is taken as a matter of course now by people. In my day, they did it but they knew it was wrong."

Recently, the report of the task force, set up to study the problem of the increase in venereal disease, came out with a plan for eradication. This appears to be rather idealistic since we have to eradicate promiscuity first. I would question if this is possible, considering the attitude of our society at the present time. Greater efforts will have to be made in order to achieve better venereal disease control. Providing there is cooperation by all groups concerned — parents, physicians, the church and official agencies — these should be successful.

Every case of early syphilis is part of a small epidemic. To stop the spread, it is vitally important to locate and treat all the other individuals who have been contacts of the infected case. Human nature being what it is, this is usually difficult. The patient may be willing to name some persons; but others he or she may not know or may conceal, for various reasons. Handling these problems of investigation and of human relations is very time-consuming and the physician who is not trained in this work cannot afford the time to do it. Greater cooperation must be established between the various departments of health and the private physicians. Epidemiology workers should be available to go to the doctors' offices and the hospital to interview patients affected.

The social problems are much more difficult if the infection has been acquired through homosexual practice and this is being seen more frequently today. Some homosexuals are extremely promiscuous and very mobile.

Of course, if we were to find a vaccine similar to those that have been so successful in the control and eradication of such conditions as smallpox, diphtheria, polio, etc., then, eradication of syphilis or gonorrhea might be possible. But is this the solution we want?

Where does the answer lie? How are we to set about controlling venereal disease? As was said earlier, promiscuous behavior is the root of the problem. The American Medical Association stated in 1910 that "a young man did not have to have premarital sex exposure to be healthy." Since then a great deal has been written about the various problems of repression and frustration that can result from sexual inhibition. Surely, we, who live in a so-called civilized society, have to experience some repression. There are many things we cannot do because we know we would be breaking the law. An individual must have self-control and this is true in sex as in other areas. Thus, as was stated at the World Forum, held recently in Washington, D.C.:

> We will not have a chance to eradicate syphilis or any other venereal disease until we have an effective sex education designed to create ideals and standards of conduct in our youth which would carry them towards successful marriage and away from promiscuous sexual activity.
>
> The main responsibility is on the parents who have to begin the education early, during the formative years, when children begin to develop their attitudes towards sex. The physician and the teacher can be of tremendous assistance to parents in teaching the facts and *this is the only way of protecting youth against venereal disease.*

Along with this, general public education programs should be set up where the dangers of infection, the signs of venereal disease and the importance of getting immediate treatment must be stressed. Doctors are the corner-stone in the effective control of venereal disease.

It is *imperative*, and this cannot be over-stressed, that once a patient has been treated in the doctor's office, the local health agency be notified promptly so that all such patients can be interviewed by expert investigators who will be able to trace down and treat *all* the infected contacts.

We never do anything well till we cease to think about the manner of doing it.

— WILLIAM HAZLITT

The heart has its reasons, which are quite unknown to the head.

BLAISE PASCAL

HEALTH AND THE STUDENT

E. MURIEL UPSHALL, B.A., B.SC.

A description of the Health service of the University of British Columbia.

Today, most Canadian universities and colleges have student health services. This has not always been so. It is by no means a new idea in university practice, having been introduced and gradually developed in the United States over the last 100 years. In 1920, the American College Health Association was organized to coordinate the thinking of the professional personnel responsible for the health of the student. A manual issued in 1964 by the Association for the guidance of student health service personnel states:[1]

> The ultimate objectives of any college or university health program are to maintain a state of optimum health, both physical and emotional, among the student body and staff, to indoctrinate each student with proper attitudes, and to instil good habits of personal and community health.

The importance of good health to the student was recognized by the administration of the University of British Columbia from its inception in 1912. Dr. Harold White, the medical director of the Vancouver School Board, was appointed to examine university students. This was done in the Outpatient Department of the Vancouver General Hospital. In 1927, a year after the University moved to its present campus, the new University Student Health Service was assigned a small office near the Administration Building. The staff comprised an acting director, who was also head of the Department of Bacteriology, and a public health nurse, whose district included the area adjacent to the campus. From this small beginning the service has developed into one of the largest and most extensive in Canada.

The year 1951 was a milestone in the department's history. The Health Service moved from an old army hut into new and much larger quarters in the first Health Sciences Centre building to be constructed on UBC campus. Dr. A. K. Young was appointed the first full-time medical director. This important expansion enabled the University to establish for the student a therapeutic service that included a 26-bed infirmary, a clinical laboratory and an x-ray unit. Until this time, the program had been essentially a preventive one. It encompassed health appraisal of students, prevention of communicable diseases, health advice and emergency first aid care.

Now, all students entering the University for the first time must have a pre-entrance medical examination by their own doctor, using a form provided by the Health Service. A certificate of recent smallpox vaccination is also required. The Health Service doctors examine special groups, such as those enrolled in physical education, nursing and medicine. Periodic health evaluation of individual students is made when advisable.

The immunization program is normally carried out in conjunction with routine clinics, but mass programs are held when occasion demands. The most recent emergency clinic was quickly organized when a foreign student was suspected of having smallpox. Almost 5,000 students and staff received vaccinations on two consecutive days. At the beginning of each session, tuberculin testing clinics are held for new students. Tuberculin, Purified Protein Derivative, is used and all positive reactors have a chest x-ray. In September 1963, 7.8 per cent showed a positive skin reaction, but there were no cases of early pulmonary tuberculosis. The Health Service is responsible for the control of communicable diseases on the campus, under regulations set up by the Board of Health of the province.

Psychiatric care is a very important

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part of a service devoted to health problems of young adults. The aim is to cope with maladjustments and emotional problems which, if not corrected early, may give rise to more serious disturbances in the future. During the 1962-63 session, 206 students were seen. An interesting fact is that 53 per cent came to us seeking help of their own accord. Sixty per cent had less than five interviews; 47.6 per cent were discharged to self. The remainder continued on with therapy under the Health Service staff or were referred to private psychiatrists; a few dropped out.

Dr. C. J. Schwarz states:[2]

> The patients seen by the psychiatric service came from almost every section of university student life, not only as regards faculty and year but also in relation to extracurricular activities. Among them were the president of one of the undergraduate faculty associations; the winner of an A.M.S. award for best student in the faculty; the captain of one of the athletic teams; a former prime minister of the model parliament; a reporter on the undergraduate newspaper, and a residency don.

The Health Service physician gives treatment to both ambulatory and hospital patients. Diagnosis is augmented by laboratory and x-ray services and other tests. Hospital care includes all drugs. The ambulatory patient may purchase medications from the Faculty of Pharmacy dispensary at a reduced rate.

Both single and married students can obtain more extensive coverage than that offered by the Health Service by contributing to a prepaid medical plan — Medical Services Incorporated. This plan provides for a physician's or specialist's care while in another hospital; medical care of accident cases; maternity benefits; specialist consultation for the ambulatory student patient.

During the 1963-64 session, 16,147 students reported to the Health Service for a total of 29,808 visits. The preventive medicine service accounted for 10,180 visits; the diagnostic and therapeutic service had 18,822. This latter service forms a large part of the Health Service program. Of the 9,124 students reporting for treatment, 595 were admitted to the hospital for an average stay of 4.5 days. The physicians had 11,596 consultations, excluding daily visits to the hospitalized students which amounted to approximately 2,689.

The most common diagnoses made in the Health Service during the 1963-64 session fell into the following groups and in this order: accidents; diseases of the respiratory system; ill-defined conditions; diseases of the skin and cellular tissues; conditions affecting the nervous system and sense organs. The number of respiratory cases depends on the incidence of an epidemic, such as the Asian influenza in the fall of 1957.

In addition to giving direct nursing care, the Health Service nurse must act as interpreter, teacher and adviser. She must be acutely aware of the young adult's problems as well as his immediate need for help in his sickness. Many students are away from home for the first time. Even the common cold can be accompanied by an undiagnosed feeling of homesickness creating a real need for a few words of reassurance. In addition to her educational and professional qualifications, the nurse who works in a university health service must be carefully selected on the basis of a mature, warm personality. The need for these rather special qualifications is illustrated in the following remarks by Dr. Nicolas Malleson:[3]

> Once it becomes known on the University grapevine or bush telegraph that there is a helpful student health service, it will be found that about 15 per cent of the students (and this figure applies throughout very much of America and in provincial universities in this country) will come during a degree course to discuss some kind of personal problem . . . .

Dr. Malleson goes on to say: "We believe that a student health service is as integral to a modern university as its seminars, its tutorials, its libraries, its lecture theatres. We believe that if there is to be universal higher education, there must be some provision to help that proportion of people who, through entirely natural growth causes, will have periods of distress and troubles and, without help, will not be able fully to realize what we can offer in the University."

(References on p. 1105)

FOOD, THE NURSE AND THE NUTRITIONIST

ROSAMOND H. ROSS, M.S. *and* DAPHNE J. SMITH, M.P.H.

How often have you heard nurses make such statements as, "I hate nutrition." "Everyone knows how to eat anyway." "There is so much food available in this country, why waste time being concerned about nutrition in a health department?" It is interesting to speculate on how some of these ideas originated.

The emphasis has shifted in nutrition programs from focusing mainly on deficiency diseases. A broader point of view includes some of the following areas of concern:

Overnutrition is probably more of a problem today than undernutrition.

The number of people in the older age bracket is increasing steadily. They may need help in meeting their food needs whether they are in their homes or in institutions.

Mass media as a method of communication may stimulate doubts, fears and confusion regarding food selection. Misleading advertising, the large number of food products for sale, too hasty interpretation of nutrition research, all add to the difficulty of sorting out true facts from misinformation. Then, too, there is the actual lack of factual information on some of the long-term effects on human beings of enrichment, pesticides, radioactivity, artificial sweeteners, trace elements, etc.

Inadequate food intake may or may not be related to income. The whole topic of "money management" needs to be considered by families in all income brackets.

The difficulties that some new Canadians have in adapting to different food habits and methods of buying indicate that they need a ready source of help. This may often be found in the person of the public health nurse.

There is some relationship between normal and therapeutic diets and the treatment and prevention of chronic disease and inborn metabolic disorders.

There is an increasing number of patients discharged from mental hospitals to the community. Many need to be taught how to manage food buying and meal preparation.

Realizing that other members of the health department, agencies and individuals in the community are also interested and involved in matters pertaining to nutrition, what responsibilities do public health nurses have in the above areas? Within the framework of the Greater Vancouver Health Service there are 140 public health nurses in the field staff and two nutrition consultants serving 657,235 people. One of the consultants spends one-third of her time with the City Social Service Department which has a staff of 40 social workers. The nurses work in a variety of settings: prenatal classes, child health centres, schools, homes, and occasionally, in institutions.

Overnutrition and Undernutrition

There is an abundance of literature concerning overnutrition and calories. The nurses, the mental hygiene staff and the nutritionists have had many discussions regarding the approach to the problem of obesity or overweight in the infant, the child and the pregnant woman. Sometimes a nurse may suggest skim or partly skim milk rather than whole milk for the "fat" baby. After two years of support and education by a public health nurse, a girl reported that she had lost 10 pounds — a major accomplishment for her.

There has been a good deal of reference made to the danger of overdosage of vitamin D. To give us some indication of the situation in Vancou-

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ver, a study* was conducted by the nutritionists on 854 infants attending child health centres. The nurses in these centres obtained the information from the mothers. The study showed that one per cent of the infants were receiving over 2,000 international units of vitamin D. The recommended daily intake should be 400 (I.U.). A reference list has been compiled for use by public health nurses, listing the sources and amounts of vitamin D in multivitamin preparations and common foods.

Nurses are aware of situations where there should be more study regarding possible malnutrition: pregnant, teenage girls, particularly those who are unmarried; those people on self-imposed calorie restricting diets; people living alone; young mothers who feed the family but depend upon cups of coffee to keep themselves going until the evening meal.

Older Age Group

There are approximately 125 licensed personal care homes in Vancouver where older people receive care and supervision. Seven public health nurses, attached to the City Social Service Department, supervise the "welfare" residents placed in these homes. Licensing regulations now include a section on food service standards. The nutritionists work along with the nurses and social workers to help maintain or improve the standard of food service in these homes.

The public health nurse asked the nutritionist to help the operator of one home to revise her menu planning as suppers seemed skimpy and uninteresting. A visit was made during the meal hour and there was time for discussion with the operator after the meal was served. Suggestions were made concerning advance planning, particularly for the supper menu, and for the employment of more kitchen help. Tested quantity recipes from the Nutrition Division, Department of National Health and Welfare were discussed and left for the operator to include in her menu planning for the next month. A written report of this visit gave the nurse points to emphasize in her follow-up visits. Joint meetings are arranged with social workers, public health nurses, nutritionists, sanitarians and representatives from the Provincial Welfare Licensing Department so that workers are better informed about the operation of the homes.

A Victorian Order of Nurses Branch is now training housekeepers to assist in the care of the aged. Nutrition and housekeeping are basic requirements in such courses. The nutritionists have given some of the classes. The curriculum was adapted from one compiled by the Community Chest and Council. It was included in a brief presented to the provincial government in order to encourage the establishment of homemaker or housekeeper service.

The "Negatives" of Mass Communication

Very often a nurse is called upon to interpret advertising statements made by food faddists or food industries that are contrary to good nutrition teaching. She may have to support the mother whose child demands a certain kind of cereal because the package contains a delightful give-away.

A nurse teaching a prenatal class was asked: "Will it be harmful to give my baby milk when milk is so full of strontium 90"? "Does washing fruit remove the harmful pesticide"? Such questions bring out the fears and doubts that people have because there is so little information about long-term effects of such materials. The nurses and nutritionists frequently find themselves sorting out fact from fad and fear, and attempting to answer questions in a meaningful positive manner without alarming anyone. At the same time one cannot be too dogmatic since today's theory may have to be discarded tomorrow because of more research.

Money Mismanagement

Nurses in their daily work are in contact with parents whose money mismanagement has a profound effect on the entire family's health and welfare. The nurse may ask for help from the nutritionist in encouraging the family to study their own problem or she can

* *Canadian Journal of Public Health*, August, 1964.

refer the case for direct help. For example, there is the history of a low-income teen-aged married couple with one baby.

The wife had no previous training in money management, either at home or in school. The nurse in the district referred the case to the nutritionist since the mother had asked for help. The mother was asked to keep a record of the family's total expenditures and a description of the food she bought. This was quite a revelation. It brought into focus the amounts spent on the large car, cigarettes and hair-spray. The wife herself had poor food habits, eating very little during the day. It will take much time to help this family sort out their values and make decisions as to the best way to spend and save their money. However, plans are afoot to have the mother attend night school classes on practical cooking. There is talk of dividing the money into envelopes and writing out market lists that will help her to control expenditures.

Food and the Mental Health Patient

Many public health nurses are involved in the rehabilitation of paients who have been discharged from mental hospitals. On one occasion a nurse telephoned to say that she was visiting such a woman. The patient had been recently widowed, had a reduced income and a family of two teen-aged children. Previously, she had been a well-organized housekeeper but now she was disorganized with her housework and had lost her confidence in shopping and preparing the family meals. We started by printing on cards some simple recipes that were familiar to her. The print had to be large since she was having difficulty with her vision as a result of her high drug intake. With support and encouragement from the nurse she gradually became able to perform household tasks and to take pride in her accomplishments. By keeping a record of her food purchases and comparing this with a low cost food plan based on Canada's Food Guide, a plan was worked out with her so that she was able to live more realistically on her reduced income. The nurse and nutritionist worked closely together throughout.

Diets and Diseases

It has been suggested that there is a possible link between diet and heart disease. However, a great deal of evidence is needed before prevention or control of heart disease by food intake can be part of a public health program. The explanation of therapeutic diets on an individual basis often confronts the public health nurse. The major difficulty seems to be in the adaptation of the diet to the home environment. The nurse may either handle the situation herself, consult with the nutritionist or have the consultant visit the home.

A nurse visited a Chinese patient, who had tuberculosis as well as diabetes, just as he and his wife were sitting down to lunch. The nurse questioned the patient about his large serving of rice. He replied that after 14 months in hospital the familiar rice tasted so good. She assured him that rice could be included in his diet but she would check the size of serving he could have. The nurse contacted the nutritionist who, in turn, telephoned the hospital dietitian to confirm the doctor's order. Food exchanges were estimated; the patient was able to enjoy his rice and other Chinese foods and yet maintain his diet. Because the patient spoke little English and the nurse could not speak Chinese, she used illustrated books with food pictures to help her.

A screening program for phenylketonuria has been started in our child health centres. The urine of babies is tested with ferric chloride solution. No doubt as this program develops the nurse and the nutritionist will become involved in the dietary management of patients with phenylketonuria.

A few years ago, faculty members from the School of Nursing, University of British Columbia and the Health Department collaborated in the preparation of the following list of desirable nutrition objectives for public health nurses.

1. To have some understanding of the relationship of food intake to the human physiological processes and to physical and emotional health:

a. To know the use and limitations of dietary standards (Canadian);

b. To know what constitutes an adequate diet during the life cycle and how this can be achieved in health and illness.

2. To understand the motivations and

forces that influence patterns of eating including sociological, psychological and cultural forces.

3. To have some understanding of buying, storing, preparing and serving food so that nutritional standards can be maintained regardless of the level of income.

4. To know how to make use of resource materials and the help of other people to increase knowledge and skill in the practice of public health nursing.

5. To use teaching principles in applying knowledge, developing skills and promoting positive attitudes to individual and group situations so that nutrition becomes an integral part of health education.

Summary

Food and people are a complex combination that constantly changes with changing cultural values, technological advances and nutrition research. The effectiveness of a nurse in promoting desirable food habits depends a great deal upon her own background and her "feeling" for food and people. We hope that nutrition is important enough to her so that she follows Canada's Food Guide in the selection of her own food. We trust that her education at home, at school — particularly in her home economics classes — in hospital, and in university is equipping her to meet the demands of her job.

Public health nurses in our agency have demonstrated that they are a vital force in helping people make wise decisions in the selection of their food. The consultants assist the nurses to interpret broader points of view in regard to nutrition in public health.

COMMUNITY HEALTH PLANNING

CATHERINE W. PERKINS, REG. N., B.SC.N.

The public health nurse is a key person in this planning.

Community organization for health is a cooperative effort that aims to improve community health and well-being. Efforts are directed towards bringing about the orderly development of a well-balanced and adequate community health program, generally through organization and coordination, rather than by giving direct service.

To achieve this orderly development of a program of comprehensive health care, it is essential to bring together the efforts, resources and interest of all organizations and individuals working in the cause of good community health. Close and effective relationships must be developed among the health and welfare agencies and within planning bodies in the community. Hence, the public health nurse must move beyond the boundaries of her own agency and work with members of other professions toward this objective.

It is generally recognized that community health services are presently undergoing changes in order to meet the challenge of modern disease problems. Public health emphases are already shifting from environmental sanitation, communicable disease control, and child and maternal health towards priorities in mental health, occupational health, chronic disease control, and better ways of providing all the kinds of health services required. The role of the public health nurse is changing too; she is rapidly becoming a member of an interdisciplinary team involving workers in many other professional fields.

It will be salutary, then, to think of the "new look" that is increasingly expected of public health nurses in their community. Comprehensive health care has been described as being:

not a precise entity, but a dynamic goal towards which we rightly strive. The rapidity of our progress will depend not only on re-

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sources in personnel, facilities and finances, but also upon the effectiveness and wisdom with which we apply them.*

We might, for immediate purposes, use the term comprehensive health care in the sense of:

the maximum possible preventive, diagnostic, therapeutic and rehabilitative services provided by qualified personnel under competent medical direction in locations — home, office, diagnostic clinic, hospital and nursing home — which are appropriate to the needs of the individual and to the service to be rendered.*

In this broadened context, there is an expanding role for the public health nurse whether she is in an executive position or a staff nurse directly serving patients. The former will take major responsibility for entering into planning for the new kinds of services required, but such service must be carried out by the staff nurse working with families in their own homes. Each must become involved and participate fully in this new dimension of public health nursing. The role of the public health nurse in planning has never been precisely defined, but it is emerging as she interprets her role to the public and as she learns how to contribute more effectively in the planning process.

Assuring Continuity of Services

In what more effective way can the knowledge and skills of the public health nurse be used than by bridging the gap between hospital and home, prior to and at the time of the patient's discharge? Her cooperative planning with the hospital head nurse, the social worker, the patient and his family, can ensure a transition that contributes positively toward, rather than detracting from, the smooth progress toward good health. This is particularly evident in her ability to relieve the patient's family of the stress of anxiety that is often unwarranted by the actual condition of the patient, and to be supportive to the patient about problems that invariably arise when the protecting atmosphere of the hospital has been left behind. Many hospitals now have a public health nurse on staff who works closely with the social worker for this precise purpose. This plan has met with marked success in ensuring continuity of services.

In many cases, the public health nurse is known to the psychiatric patient's family before the onset of the illness. She is, thus, at the time of the patient's discharge, in a good position to interpret to the family the role of the other disciplines, and to work cooperatively with them in carrying out post-hospital plans. Collaborative planning of this nature and cooperative action to help the patient resume his place in society can be of the utmost value in preventing further illness and possible readmission. The case conference is an effective method of carrying out this kind of planning, and is being increasingly used by health and welfare agencies.

There is a trend in psychiatric hospitals to set up positions for "liaison nurses." Their function is to arrange for the provision of continuing health supervision and, in cooperation with workers of other disciplines, for the supportive services the patient requires. The public health nurse serving the district is the logical person to provide such supervision. It is thus essential to ensure that the staff have adequate psychiatric training and experience to fit them for this role. In addition, they must be prepared to work cooperatively with workers from other disciplines.

Staff nurses in public health agencies will also be increasingly called upon to provide supervision for patients discharged to boarding homes after a long stay in a psychiatric hospital. Only if these patients have continuing health supervision, with occupational and diversional therapy and some help with the activities of daily social living, can they leave the sheltered environment of the hospital and attempt to regain their place in society. The nurse and the social worker are both needed to help the patient with this transition, and to assist the boarding home operator in her sustaining role.

Considerable thought is presently being given by planners of health services to the need for additional facilities of various kinds: day hospitals, foster

* W. Palmer Dearing, The Challenge of Comprehensive Care, *A.J.P.H.* Dec. 1962.

homes and day care centres for the elderly. The public health nurse is invaluable to the planning groups since she can bring her first-hand observations of the daily lives of patients, through which their health needs are made evident. She can describe the kinds of help and degree of health supervision that should be available in boarding homes for the elderly; she has an awareness of the ability or inability of the handicapped to function independently; and she daily meets with the problems of families trying to keep a number of appointments with the multiplicity of agencies by which they are being served. The inclusion on the planning groups of a public health nurse, skilled in group participation, with a sound knowledge of the people in her community, brings a dynamic quality to the planning process that can scarcely be achieved on a theoretical basis alone.

The public health nurse also has a contribution to make in the area of standard-setting. While standards in hospitals in Canada can be assured by accreditation by the Canadian Council on Accreditation, nursing homes and rest homes are without similar guidance. In B.C., for instance, except for provincial government regulations, standards of care for such homes are not generally outlined, unless it is by the action of local groups. The public health nurse can be helpful in bringing a practical approach to this problem in order to prevent the formulation of standards that, although desirable, are impossible to meet without a major readjustment of present methods. Meeting such standards may be so disturbing that owners become discouraged and a much-needed facility may be lost.

One may justifiably ask why the public health nurse is a key person in the planning of community health services, when there are other disciplines involved and other persons who may seem more knowledgeable about the community's needs. But is there in the community any other person or group of persons with the training, the skills and the opportunity to learn so intimately of the health status, functioning and needs of the people making up that community? The nurse is one professional person whose work is carried on mainly through visits in the home, complementing work done in clinic, agency office, hospital or school. She has a knowledge of all the factors contributing to or detracting from the attainment of optimal health; she is familiar with community resources and methods of referral; and she is in a good position to carry out a coordinating role in connection with the provision of services necessary for total health. Her familiarity with how families function in their own homes brings a personal element into the planning process that vitalizes it and relates it to the daily lives of the patients.

Fulfilling Her Role

How can public health nurses become more aware of their role in the health planning process? By what methods can their participation be made more effective? Three essentials must be developed before the public health nurse will be able to take her proper place in planning: knowledge of the community; skill in inter-professional communication, and willingness to participate in group planning.

By knowledge of the community is meant an intimate knowledge of the policies and program of all resources in the health and welfare field. This cannot be acquired by reference to "Directories of Services" with their brief statements of purpose and methods. It requires visits to agencies, attendance at annual meetings, study of annual reports, and face-to-face discussions with staff of other health and welfare agencies and government departments.

Nurses must keep abreast of the philosophy and trends in service in agencies, and be aware of demographic changes in her area; growing concentrations of ethnic groupings in certain sectors; changing patterns in the age range of persons seeking care, and the group behavior of adolescents in the district. Factors such as these may be the first indicators of a future need for special kinds of services.

This knowledge of the community can only be of value if it is communicated to those persons who are in a position to plan the necessary health services. It can be brought to the at-

tention of the supervisor and entered into narrative reports by the nurse. But there is special value in being able to communicate her observations and her thinking directly to the persons who need that particular knowledge of the community. It has been observed that many nurses are valuable contributors to discussions in committees or conferences. However, there is a large number who require help in filling this role. They need encouragement to look at their work as one vital part of the total picture of how people are provided with health services — a part about which no one will know without being told — and it is their duty to do the telling. This is made easier by practice in participating in group discussions which include other disciplines besides nursing; through case conferences, and by taking part in the work of small committees where a specific task in the health field is undertaken.

The public health nurse must be given every opportunity to learn how health planning is done in her community and, if possible, to become involved in the process. It is only through joining with other professional groups and interpreting her role to them that she is able to see her own work as one piece of mosaic in the total pattern of service. In the process she becomes more intimately acquainted with the purposes and methods of other disciplines and learns to respect their contribution.

Schools of public health nursing have a responsibility to equip their students so that they can fill this emerging role — which is by no means a new one, but which is becoming clearer as they learn to contribute with maximum effectiveness to the planning process.

When she is able to see beyond the immediate boundaries of her day-to-day work, and to take her unique place in the broad picture of services to the people along with other disciplines, only then will the public health nurse be making her maximum contribution to the health of the community.

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OCCUPATIONAL HEALTH NURSING

MARGARET C. STEWART, B.S.N.

A discussion of factors that influence the nurse's role.

Approximately 50 nurses are engaged in occupational health nursing in British Columbia. If each were asked about her work there would undoubtedly be a variety of replies. These health services vary according to many factors, and possibly a picture of the nurse's role will evolve if three of these are considered: the type of industry; the number of people employed; and the attitudes of management. As well as discussing these external determinants, it is important to consider how the nurse sees herself in relation to the total program.

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Type of Industry

One thinks of forestry and fishing as the major industries in British Columbia and, indeed, a large part of the labor force is employed in these two areas. Many people work in the more remote areas of the province where first aid services are provided as required, usually by a first aid attendant certified by the Workmen's Compensation Board. Rarely does a nurse provide this type of service in these far-flung locations. The major-

ity of nurses work in the more heavily populated, more industrialized, southwest corner of the province where almost every industry and business activity is represented. The oil industry, department stores, public utilities and packing plants are just a few of the companies that employ nurses. It has been of interest to note the development, within the last five years, of occupational health services for two large groups: the employees of the city of Vancouver and the staff of the Vancouver General Hospital. Obviously, these diverse activities present different problems and necessitate the implementation of a variety of procedures to prevent illness and accidents and to promote health.

Number of Employees

A few firms in B.C. employ a full-time medical director, two or more nurses, x-ray and laboratory technicians and clerical assistants; others, not quite as large, employ part-time physicians and one or more nurses. Still other companies, not large enough to utilize the services of a full-time nurse, have found the part-time service of the Victorian Order of Nurses to be an effective method of bringing a health program to their employees.

Attitude of Management

A growing number of employers recognize the importance of providing health services beyond the level of immediate care for the workman injured on the job. Some firms have programs that embody the recommendations outlined in the Canadian Medical Association's publication, *Guiding Principles for the Provision of Occupational Health Services*. This outline suggests:

A good occupational health program should include:

1. Measures for the maintenance and improvement of health and the prevention of disease.
2. Pre-employment, periodic and special medical examinations.
3. Provision for immediate emergency care and advice for minor and major injury and illness on the job.
4. Diagnostic and counseling services.
5. An industrial hygiene program to detect, assess and recommend control measures for environmental health hazards.
6. Cooperation with the company safety program to reduce the number of accidents.
7. Provision of a health education program for the worker and his family, in order to improve his health, work, efficiency, morale, and productivity.
8. Maintenance of adequate statistical records of diseases and injuries in the employee population.
9. Liaison with private medical practitioners, local medical societies and health and welfare agencies.
10. Advice to management and labor on prepaid health insurance and pension plans, sick benefit plans and other matters related to the medical care of the employees.

If a nurse is fortunate enough to be employed in a company which adopts such a program, her scope is broadened considerably, as are the benefits to the community, the industry, and the employee as an individual.

In looking at herself in relation to her work, the nurse sometimes has a few qualms about her abilities to fulfill the requirements of the company, maintain her professional standards and meet the needs of the employees in whom she soon develops a very warm interest. The Occupational Health Nurses' Group of the Registered Nurses' Association of British Columbia has been of great value. It has provided occupational health nurses with an opportunity to meet together to "talk shop" and air problems — an opportunity which the nurse who works alone misses. In 1957, the group prepared a publication called *Duties and Responsibilities of Occupational Health Nurses* to assist the nurse to interpret her functions more easily. Another helpful activity of this group is to arrange educational programs in response to requests. The latest of these was a series of lectures and discussions on counseling given by the Department of Psychiatry, Faculty of Medicine, University of British Columbia. The effort met with great enthusiasm.

The picture of the occupational health nurse in B.C. must mirror that of nurses all across Canada. Progress is being made but there is still much to be done. This makes this area of nursing a stimulating and dynamic one in which to be involved.

THE WORLD OF NURSING

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
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Food for Thought

The excellent editorial that appeared in the July 24 issue of *Nursing Mirror* is, we believe, worth repeating. Read it. We think you will agree it contains food for thought.

One of the members of the *Nursing Mirror* study group said, on returning to England after fifteen days in Canada and the United States, "It is as if the scales have dropped from my eyes. Why, oh why, didn't I do this twenty years ago?"

Travel abroad, particularly if it is an experience one does not have till later in life, can prove preconceived notions based on books, films and the stories of returning travellers to be way, way out. Expected differences emerge as similarities, and vice versa. You are smitten, on the one hand, with shock that people and places can be so unlike the homeland, and, on the other, that they can be so very much the same.

The biggest surprise is often contained in the return home. A building in London, England, which was never noticed before turns out to be identical with the one which caused so much interest in Montreal, Canada. A dress which was thought of when you saw it in Washington, U.S.A., as "typically American," passes by on the back of a typically English secretary. A piece of equipment which you thought so advanced in a New York unit turns up again in a London teaching hospital where it has been in use for years.

Were you blind, you wonder, when you left home? How much more is there to see, right here in Britain? Do we have eyes to see when we are in a situation so new that nothing can be taken for granted?

Travel is undoubtedly an education. And one of its most intriguing lessons is how little we know about ourselves.

More About the ICN Congress

What to wear

Word from the German Nurses' Federation is that temperatures in June can range from 61° to 86° but that the nights are mainly cool. Some rain can be expected. So plan your wardrobe accordingly.

Bring along a cocktail dress or short evening dress for official receptions and social events. Long gowns will not be worn.

Currency

1 Deutsche Mark (DM)
— 100 Pfennig
1 American Dollar
— 4 Deutsche Mark
20 Pfennig
1 English Pound
— 11 Deutsche Mark

Banking offices will be available at the airport, the railway station and the registration centre.

Meals

As indicated on the blue registration form, hotel charges do not include breakfast. The price range is between 2 DM 50 p to 5 DM.

Lunch, which is the main meal in Germany, will be provided for all delegates on the grounds where the meetings are held. Rates for lunch will range between 3 DM 50 p to 6 DM. Evening meal rates range between 3 DM 50 p to 8 DM. Snacks and hot and cold drinks will be available at snack bars on the exhibition grounds at all times at a nominal charge.

Local transportation

The cost of transportation from the airport to the city (main railway station) will be 2 DM. Special tickets may be purchased for buses and street-

CNA executive director attends fourth biennial conference of Caribbean Nurses Organization in St. Croix. Left to right, front row: MRS. E. OSBORNE *(NLN);* MRS. F. BLANCHETTE *(president CNO);* MISS FRANCES BECK *(ICN). Left to right, second row:* MISS MARGARET HASTINGS, MISS NITA BARROW, MISS JANET THOMPSON, DR. H. K. MUSSALLEM, MRS. MANIS BROWN.

cars during the congress. They will be sold at the airport, the railway station and the registration centre. The cost, we are told, will be reasonable.

Shopping

Shopping hours are generally from 8:30 A.M. until 6:30 P.M. On the outskirts of the city, shops are closed between 1:00 P.M. and 3:00 P.M. All shops close at 2:00 P.M. on Saturdays.

Postal facilities

Post offices will be found on the exhibition grounds where you will be able to get special congress post cards for mailing. Unfortunately, there will be no special stamps for the congress.

NLN Launches National Survey of Nursing Service

A major national study of the operation and organization of hospital nursing services is being undertaken by the Department of Hospital Nursing of the National League for Nursing. According to the League's August *Bulletin,* this is the first comprehensive study of its kind. It was initiated with the mailing of a questionnaire containing 29 major questions to 1,600 representative voluntary, general, short-term hospitals. It was designed specifically to give a comprehensive picture of the current status of nursing service administration in hospitals; to serve as a baseline for subsequent studies; and to identify trends.

Says the *Bulletin*: "It is hoped that the questionnaire will not only yield important information on all phases of hospital nursing services but will also spotlight the particular areas that need to be studied in depth."

Wins RNAO Fellowship

A 1956 graduate of the University of Toronto School of Nursing is back there this year studying for her master's degree. Through this fellowship award, M. J. FLAHERTY plans to major in medical educational theory with minors in epidemiology and medical statistics.

Miss Flaherty has worked at a Red Cross Outpost Hospital and spent two years as an assistant in the medical research department of the University of Toronto. She joined the faculty of the Nightingale School of Nursing in 1960 as an instructor and in 1962 returned to the University of Toronto as a lecturer.

This is the second such award made by the RNAO.

Joins National Office Staff

MARGARET LILLIAN PARKIN has

(The Fairlight Co. Photographers Ltd., London, Eng.)

CNA associate executive director attends reception during a recent meeting of the ICN Legislation and By-Laws Committee in London. Left to right: MRS. GROSSMAN *(U.S.A.);* MISS CREELMAN *(WHO);* MISS MAGNUSSEN *(Denmark);* LORD COBBOLD; MISS PETTIGREW *and* MISS WRIGHT *(Canada;)* MISS UDELL *and* MISS MARRIOTT *(Great Britain).*

been appointed librarian for the Canadian Nurses' Association and has taken up her duties in Ottawa.

In her new assignment, Miss Parkin will organize and develop a specialized library on the nursing profession and related subjects and will provide reference and other information services for professional and editorial staff of the CNA. She will also represent the interests of the CNA in library and bibliographic circles.

Born in Ottawa, Miss Parkin received her Bachelor of Arts degree from the University of Toronto and her Bachelor of Library Science degree from the University of Ottawa, where she received the university medal for the highest standing in library science.

Miss Parkin's experience includes service with the Ottawa Public Library, the Northern Electric Research Establishment, the federal Department of Labor and Carleton University.

Regina Nurse Shares in $1,000 Scholarship

LORNA BARKER of Regina has been named as one of four recipients of a $1,000 scholarship offered by the Saskatchewan Registered Nurses' Association. Miss Barker, who is enrolled at the University of Alberta, has been awarded $250. Other recipients are ELEANOR HEIRON, SHIRLEY ADAMS and DONALD BROWN, all of Saskatoon.

The SRNA scholarship fund was established this year for the purpose of providing financial assistance to registered nurses for postgraduate study in doctorate, master's or final year baccalaureate programs. The fund is financed from interest received from association investments, donations and endowments.

Scholarships Awarded by NBARN

"The Muriel Archibald Scholarship" of $1,000 has been awarded to BETTE D. PATTERSON of Lancaster, N.B. Miss Patterson is completing her Bachelor of Nursing degree at the School for Graduate Nurses, McGill University.

"The New Brunswick Association of Registered Nurses Scholarship" of $1,000 has been divided between EVELYN EGERS, Chipman, N.B. and RUBY MURIEL CLARK, Dipper Harbour, N.B. Both are students at the school of nursing, University of New Brunswick, degree program.

Nursing Profiles

Elaine (Snell) McClintock has been appointed assistant director, nursing education, Brockville General Hospital. Mrs. McClintock was born and educated in British Columbia, entered U.B.C. School of Nursing on a scholarship, and was graduated with a B.Sc.N. degree in 1957.

Her past experience includes V.O.N. nursing — as a staff nurse and as nurse-in-charge at the Brockville Unit — and several years as medical-surgical instructor at the Brockville General Hospital. Since 1962, Mrs. McClintock has been on the executive of the Brockville Chapter, RNAO, this year serving as President. She is also first vice-president of District 7, RNAO.

Despite these many professional responsibilities, Mrs. McClintock still manages to find time, with her husband and four-year old son Jamie, to enjoy boating and swimming on the St.Lawrence River, gardening, raising tropical fish and a cocker spaniel! She is an avid bridge player and photographer.

Mrs. McClintock brings to her new position a rich fund of experience and professional ability.

ELAINE MCCLINTOCK

Early this year, Laval University, Quebec City, anounced the appointment of **Noëlla Bertrand** as director of the school of nursing science and president of the board of management of the school. This is the first time that this position has been held by a lay nurse.

NOËLLA BERTRAND

Miss Bertrand obtained her bachelor of arts degree from Collège Basile-Moreau before entering the school of nursing, Notre Dame Hospital, Montreal. Following her graduation in 1952, she remained on staff for a year as an assistant head nurse. In 1954 she completed requirements for her bachelor of nursing science from Institut Marguerite d'Youville, Montreal, and in February of this year she was granted her master's degree in nursing science from The Catholic University of America, Washington. She is a former instructor and assistant director of the school of nursing, Notre Dame Hospital, Montreal. In addition to her professional preparation, Miss Bertrand is an accomplished singer and pianist.

In July of this year, **Winnifred M. Day** assumed the responsibilities of director of education, Municipal Hospital, Medicine Hat, Alberta.

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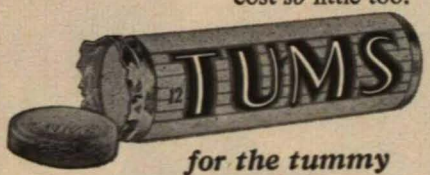

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Miss Day is a graduate of the Hospital for Sick Children, Toronto, and the University of Western Ontario where she received a B.Sc.N. degree. Her experience in nursing has been varied and has taken her to many parts of Canada. Positions she has held include those of staff nurse, head nurse and educational director. Her most recent position was with the Calgary General Hospital.

Miss Day's interests outside of nursing are widely diversified. They include the Soroptimist Club, United Church Women, music and a variety of handicrafts.

In Memoriam

Alice (Hedge) Arkell '10, Guelph General Hospital, Ont.

J. J. Brown '10, Guelph General Hospital, Ont.

Doris W. (Ward) Casey '25, Queen Victoria Hospital, North Bay, Ont.

Margaret (Killeen) Copas '26, St. Paul's Hospital, Vancouver, B.C.

Frances (Reid) Fisher '12, Montreal General Hospital, Que.

Vera (Forsythe) Gordon '32, Guelph General Hospital, Ont.

Mona (Daigle) Graham '50, Hotel Dieu Hospital, Edmunston, N.B.

Marilyn P. (Hope) Haines '55, Winnipeg General Hospital, Man.

Mabel K. (Holton) Holmes '40, Edmonton General Hospital, Alta.

Henrietta Isbister '12, Royal Victoria Hospital, Barrie, Ont.

Sarah Livingstone '15, Guelph General Hospital, Ont.

Jennie (McKim) Mavor '19, Victoria Public Hospital, Fredericton, N.B.

M. Jean (Fotheringham) Morse '38, Brandon General Hospital, Man.

Muriel E. (McMurray) Robertson '26, Royal Alexandra Hospital, Edmonton, Alta.

Carol Mae Simpson '62, Hotel Dieu Hospital, Windsor, Ont.

Mary Constance E. Stevenson '19, Vancouver General Hospital, B.C.

Blanche (Bleeks) Walters '19, Lady Stanley Institute, Ottawa, Ont.

Jennie Wilson '26, Edmonton General Hospital, Alta.

Lucy A. (Alspach) Workman '44, Holy Cross Hospital, Calgary, Alta.

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(Continued from p. 1091)

References

1. "Recommended Standards and Practices for a College Health Program," American College Health Association, 1964.

2. C. J. Schwarz, "A Psychiatric Service for University Students," *Canadian Psychiatric Association Journal*, June 1964, p. 232-38.

3. N. Malleson, "The Student Health Service," Address to Meeting of Convocation of the University of London, October 8, 1963.

ABSENTEE RATE

A recently published study of men and women doing similar work in a telephone company in the U.S.A. revealed that women had a higher absentee rate than men as a result of illness.

Among these employees, whose work records had been studied over a period of 20 years, both the average number of days of absence and the average number of absences per individual had been found to be higher for women than for men. This study also showed that women were more susceptible to mental and nervous disorders, high blood pressure, varicose veins, arthritis and rheumatism. On the other hand, tuberculosis, asthma, heart conditions and peptic ulcers had occured more frequently among the men.

— The Labour Gazette
March 1964

Anne McMahon trained in midwifery, was a suture nurse in Ireland. She found her O.R. background invaluable for her work as a nurse anesthetist at Roosevelt.

Miss Betty Jane Smith, C.R.N.A. C-10
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The Roosevelt Hospital
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The Canadian Nurses' Association has not yet reviewed the personnel policies of the hospitals and agencies advertising in the Journal. For authentic information, prospective applicants should apply to the Registered Nurses' Association of the Province in which they are interested in working.

Address correspondence to:

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Registered Nurses for a busy 51-bed active treatment hospital, situated in east central Alberta. Salary range from $340-$385 commensurate with experience. Sick leave and pension benefits available, 40 hour work week, 21 days annual vacation plus statutory holidays, full maintenance in new nurses' residence for $30/m. For further information, apply to: Miss Margaret MacIntosh, Director of Nursing, Municipal Hospital, **ELK POINT,** Alberta. 1-34-1

Registered Nurses (2) for 20-bed and 8 bassinette active treatment hospital. Starting salary $350/m, full maintenance at $35 in modern nurses' residence, good working conditions, policies on request. Apply to: Matron, Municipal Hospital, Myrnam, Alberta. 1-66-1

Registered Nurses for busy 44-bed active treatment hospital, salary $335/m with bi-yearly increments; differential for past experience. 40-hr. wk. Excellent accommodation in new nurses' residence. Medical, hospitalization and pension plans, liberal holiday, vacation and sick schedule. Apply: Holy Cross Hospital, Box 339, Spirit River, Alberta. 1-81-1

Registered Nurses for General Duty in active 21-bed hospital. Salary $315 to $360 per month depending on years of experience. M.S.I. and pension plan. 21 days vacation per year plus nine statutory holidays. For further particulars apply to: Director of Nursing, Berwyn Municipal Hospital, Berwyn, Alberta. 1-8-1

Registered Nurses for General Duty (O.R. training helpful). Starting salary $330 annual increments to $360, board and room $30/m. Group medical insurance and pension plans available. Please do not apply unless prepared to accept position. Apply to: The Matron, General Hospital, Bow Island, Alberta. 1-11-2

General Duty Nurses for well-equipped 76-bed hospital in active town of 3,000. Salary $315-$360 for Alberta registered; $305-$350 for non-Alberta registered. New separate residence, excellent personnel policies and working conditions. Apply to: Director of Nursing, Brooks General Hospital, Brooks, Alberta. 1-13-1

General Duty Nurses. Starting salary: $315 per mo., 40 hr. work wk. Room, board & laundry available, if desired, at nominal rates. Civil Service holiday, sick leave & pension benefits. Apply to: Baker Memorial Sanatorium, Dept. of Public Health, Calgary, Alberta. 1-14-3

General Duty Nurses (2) for modern 25-bed hospital on Highway No. 12. Salary range $340 to $385. New staff residence. Full maintenance $35, personnel policies include Blue Cross, M.S.I. and pension plans. 21 days' vacation per year, plus statutory holidays. Apply to the: Director of Nurses, Municipal Hospital, Coronation, Alberta. 1-25-1

General Duty Nurse for active 27-bed hospital. Modern industrial town 16 miles from Jasper Park on Mainline C.N.R. Interest in operating room an asset. Salary as per AARN recommendation. Full board in modern residence $35 monthly. Apply: Director of Nursing, Hinton Municipal Hospital, Hinton, Alberta. 1-47-1A

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Those interested in positions at the following locations should write to: Fisher River Hospital, HODGSON, MAN.; Miller Bay Hospital, PRINCE RUPERT, B.C.; Moose Factory Hospital, MOOSE FACTORY, ONT.; Norway House Hospital, NORWAY HOUSE, MAN.; Sioux Lookout Indian Hospital, SIOUX LOOKOUT, ONT.; Nanaimo Indian Hospital, NANAIMO, B.C.

Information on these and other positions is available from Medical Services Directorate, Department of National Health and Welfare, in Vancouver, Edmonton, Regina, Winnipeg, Ottawa and Quebec or from the

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Graduate Nurses. Salary: $315 to $360/m. 5 day, 40-hr. wk., 31 days paid vacation after 12 mo. continuous employment, also generous sick time and pension benefits. For further particulars please apply to: M. Hawkes, R.N., Superintendent of Nurses, Municipal Hospital, Drumheller, Alberta. 1-31-2

GRADUATE NURSES for General Duty, differential for advanced preparation in Psychiatric Nursing. Salary $315 - $375/m, 40-hr. wk., Civil Service holiday, sick leave and pension benefits, good personnel policies. This is an active treatment Mental Hospital conducting an approved School of Nursing, 60 miles from Edmonton. Apply to: Director of Nursing, Provincial Mental Hospital, Ponoka, Alberta, giving full particulars. 1-72-2

Staff Nurses (2) by The Athabasca Health Unit for the Lac La Biche sub-office. P.H. Nurses preferred but R.N.'s considered. Salary in accordance with qualifications and experience, based on L.H.S. 5 schedule. Applications to: Miss E. Schinkinger, Senior Nurse, Athabasca Health Unit, Athabasca, Alberta. 1-1-2

NURSES fully qualified for 30-bed active treatment hospital. New hospital building and recently renovated nurses' residence. Unless definitely interested in coming, please do not apply. Personnel policies sent upon request. Apply to: Mrs. M. Hislop, Superintendent, General Hospital, Bassano, Alberta. 1-5-1

Nurse required immediately for Sub-office. Generalized public health nursing program. Car provided. Applications to: Medical Officer of Health, Peace River Health Unit No. 21, Peace River, Alberta. 1-69-2

Nurses for 40-bed hospital in town of 1,600 pop., modern residence. Salary $315/m, but will consider further inducements. Board and room $20/m, group insurance and pension, 3-wk. vacation plus 9 statutory days. Town located 70-mi. midway between Calgary and Lethbridge, paved highways, serviced by train and bus, other facilities swimming pool, golf course, curling, proximity to National Parks, mountains, ranches and is centre of large wheat growing area. Apply in writing to: Mr. F. A. Wythe, Administrator, Municipal Hospital, Box 299, Vulcan, Alberta. 1-93-1

BRITISH COLUMBIA

Nursing Supervisors (2) Salary (1964) $384 - $467; (1965) $394 - $478. **Head Nurse** (1) for Obstetrical and Surgical Wards. Salary (1964) $366 - $445; (1965) $375 - $456. Postgraduate preparation or several years experience preferred. All RNABC policies in effect. Medical Health Plan, Superannuation. Apply to: Director of Nursing, Cariboo Memorial Hospital, Box 430, Williams Lake, British Columbia. 2-80-1A

Operating Room Head Nurse (Experienced) with postgraduate course for modern accredited 82-bed hospital. Salary: $381-$460 according to experience plus RNABC allowance for postgraduate course. Accommodation available, 10 statutory holidays, 4-wk. vacation, superannuation and medical plan coverage. Apply: Director of Nursing, General Hospital, Kitimat, British Columbia. 2-36-1A

Registered or Graduate Nurses (3) for 15-bed hospital, situated on the beautiful Arrow Lakes, B.C. Standard B.C. salaries, holidays, 40-hr. wk., living accommodations at low cost. Apply to: Administrator, Arrow Lakes Hospital, P.O. Box 87, Nakusp, British Columbia. 2-45-1

Registered or Graduate General Duty Nurses for active 25-bed hospital. Salary B.C. registered $320 to start; unregistered $305. RNABC personnel policies in effect, nurses' residence available. Apply: Administrator, Lady Minto Hospital, Ashcroft, British Columbia. 2-4-1

Registered Nurses or Graduate Nurses for 75-bed hospital opened in September 1962. Salary B.C. registered nurse $332-$404; salary non-registered nurse $317, RNABC policies in effect. Very active town in Cariboo Ranching country. Apply: Director of Nursing, Cariboo Memorial Hospital, Williams Lake, British Columbia. 2-80-1

General Duty Nurses (2) for 30-bed active hospital (Accredited). RNABC policies in effect. Apply: Director of Nursing, Creston Valley Hospital, Creston, British Columbia. 2-16-1

General Duty Nurses for active 30-bed hospital. RNABC policies and schedules in effect, also Northern allowance. Accommodations available in residence. Apply: Director of Nursing, General Hospital, Fort Nelson, British Columbia. 2-23-1

General Duty Nurses for new 30-bed hospital located in excellent recreational area. Salary and personnel policies in accordance with RNABC. Comfortable Nurses' home. Apply: Director of Nursing, Boundary Hospital, Grand Forks, British Columbia. 2-27-2

General Duty Nurses for fully accredited 113-bed hospital (82 beds in use) in N.W. B.C. Excellent fishing, skiing, skating, curling and bowling. Hot springs swimming within 20 minutes. 1964 salaries B.C. Registered $347 - $419. Non-Registered $332. Room and board $50/month. 10 statutory holidays, 1½ days sick leave, 4 weeks vacation. Superannuation and Medical Plan coverage. Apply: Director of Nursing, Kitimat General Hospital, Kitimat, British Columbia. 2-36-1

General Duty, Operating Room and Experienced Obstetrical Nurses for 434-bed hospital with school of nursing. Salary: $332-$404. Credit for past experience and postgraduate training. 40-hr. wk. Statutory holidays. Annual increments; cumulative sick leave; pension plan; 28-days annual vacation; B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia. 2-73-13

General Duty Nurses for 110-bed hospital in northwestern B.C. Salary—B.C. registered $347-$419; non-registered $332. Newly furnished residence with T.V. Good social activities, including bowlin, curling, tennis and year-round swimming. Full personnel benefits including travel allowance. Apply to: Director of Nursing, General Hospital, Prince Rupert, British Columbia. 2-58-2

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General Duty Nurses (2) for modern active 21-bed hospital on West Coast of Vancouver Island. Salary B.C. Registered $332 to start; unregistered $317 increasing in January 1965. RNABC personnel policies in effect. Room and board in modern nurses' residence $40/m. Apply: Matron, TOFINO GENERAL HOSPITAL, TOFINO, BRITISH COLUMBIA. 2-71-1

General Duty and experienced Operating Room Nurses for 50-bed active hospital in northwestern B.C. 1964 salaries: B.C. Registered, $347, Non-Registered, $332. RNABC personnel policies in effect. Planned rotation. New residence, room and board: $50/m. T.V. and good social activities. Write: Director of Nursing, Box 1297, Terrace, British Columbia. 2-70-2

Graduate Nurses for 60-bed modern hospital in resort area on Vancouver Island. R.N. basic rate $332/m with yearly increments according to RNABC personnel policies. Enquiries: Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia. 2-9-1

Graduate Nurses and Certified Nursing Assistants for 70-bed acute General Hospital on Pacific Coast. Salary for Graduates in accordance with RNABC scale with credit for experience; Nursing Assistants $220-$253 Board and room $25/m; 4-wk. vacation after 1-yr. Superannuation and medical plans. Apply: Director of Nursing, St. George's Hospital, Alert Bay, British Columbia. 2-2-1

Operating Room, Obs. and General Duty Nurses for modern 450-bed hospital with a school of nursing. RNABC policies in effect. Salary $332/m. Credit for past experience and postgraduate training. 40-hr. wk., 10 statutory holidays, annual increments, cumulative sick leave, pension plan, 28-day annual vacation. B.C. registration required. For particulars write to: Director of Nursing Service, St. Joseph's Hospital, Victoria, Vancouver Island, British Columbia. 2-76-5

Two Nurses WANTED for Christian service in a mission hospital of the United Church in Northern B.C. Apply: Wrinch Memorial Hospital, Hazelton, British Columbia. 2-29-1

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Registered and Practical Nurses (immediately) for 18-bed hospital at Vita, Man., 70-mi. from Winnipeg. Starting salary, R.N. $330 - L.P.N. $225, with allowance for experience. Daily bus service. 40-hr. wk., full maintenance available for $50/m. Apply to: Matron, District Hospital, Vita, Manitoba. 3-68-1

General Duty and Licensed Practical Nurses for 100-bed active treatment hospital with newly opened 35 bed extended treatment wing. 40 hour work week, excellent personnel policies, residence facilities. Situated in the parkland, just a few miles from Clear Lake summer resort and Agassiz ski resort. Apply to: Mrs. M. Paul, R.N., Director of Nursing, General Hospital, Dauphin, Manitoba. 3-17-1

General Duty Nurses (3) for new 85-bed hospital. Good salary and generous personnel policies. Apply: Director of Nursing, Portage Hospital District No. 18, Portage La Prairie, Manitoba. 3-45-1

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Registered Nurses for 21-bed hospital in pleasant community — Eastern Shore of Nova Scotia. Apply: Superintendent, Eastern Shore Memorial Hospital, Sheet Harbour, Nova Scotia. 6-32-1

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply: Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia. 6-21-1

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Director of Nurses for well-equipped 42-bed General Hospital located in heart of area known for its wealth of natural resources. The sportsminded person has unlimited activities to enjoy. Residence suite available. For further information please phone or write: The Administrator, Sioux Lookout General Hospital, P.O. Box 909, Sioux Lookout, Ontario. 7-119-1A

DIRECTOR OF NURSING for new 34-bed General Hospital to be opened in December, 1964. A postgraduate course and previous administrative experience desirable. Salary commensurate with qualifications and experience. Residence accommodation available. For further information, please phone or write: Administrator, Louise Marshall Hospital, Mount Forest, Ontario. 7-82-1

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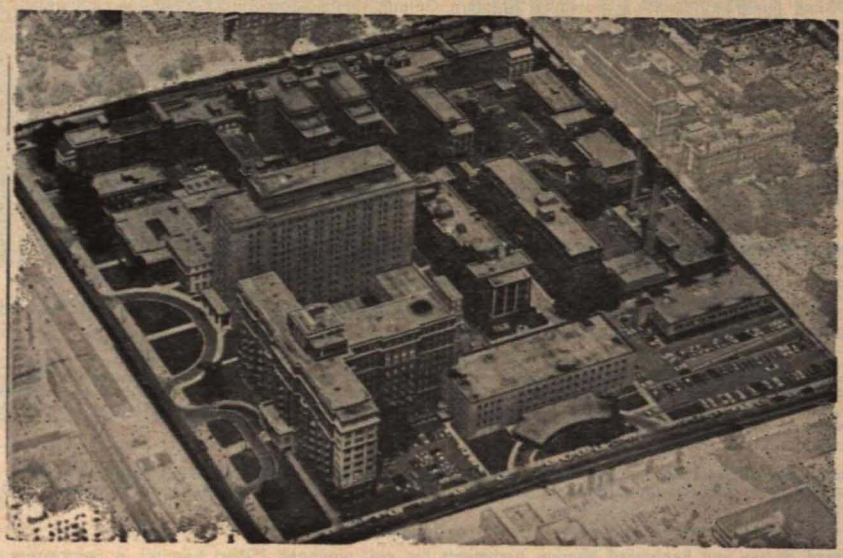

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Sudbury Algoma Sanatorium, Sudbury, Ontario.

REGISTERED NURSES REQUIRED

FOR GENERAL DUTY IN MODERN 18-BED PRIVATE HOSPITAL IN IRON MINING TOWN, 140 miles north of Sault Ste. Marie, Ontario. SALARY RANGE $330 MINIMUM TO $377 MAXIMUM. Allowance for experience. Board and room available at $20 per month. Transportation allowance up to $50 after 6 months.

Apply:

SUPERINTENDENT OF NURSES, LADY DUNN HOSPITAL, WAWA, ONTARIO

Registered Nurses for new 65-bed hospital. Resort area. Salary range: $315/m. Up-to-date personnel policies. Apply: Director of Nurses, South Muskoka Memorial Hospital, Bracebridge, Ontario. 7-15-1

Registered Nurses for Surgical, Medical, Pediatric, Obstetrical Departments and Operating Room, required by 100-bed General Hospital, situated in Northern Ontario. Starting salary $360, annual increments, good personnel policies, including 40 hours per week. O.H.A. pension plan and group life insurance, O.H.S.C. and P.S.I. plans in effect. Accommodation available in residence if desired. For further particulars apply to: Director of Nurses, Lady Minto Hospital, Cochrane, Ontario. 7-30-1

Registered Nurses for 34-bed hospital, min. salary $350/m. — max. of $450 in five years, 3-wk. vacation with pay, sick leave after 6-mo. service. **All Staff** — 5 day 40-hr. wk., 9 statutory holidays, pension plan and other benefits. Apply to: Superintendent, Englehart & District Hospital, Englehart, Ontario. 7-40-1

Registered Nurse for 70-bed accredited hospital. Good salary and personnel policies. Apply to: Director of Nursing, Alexandra Hospital, Ingersoll, Ontario. 7-60-1

Registered Nurses. Applications and enquiries are invited for general duty positions on the staff of the Manitouwadge General Hospital. Excellent salary and fringe benefits. Liberal policies regarding accommodation and vacation. Modern well-equipped 33-bed hospital in new mining town, about 250-mi. east of Port Arthur and north-west of White River, Ontario. Pop. 3,500. Nurses' residence comprises individual self-contained apts. Apply, stating qualifications, experience, age, marital status, phone number, etc. to the Administrator, General Hospital, Manitouwadge, Ontario. Phone 826-3251. 7-74-1A

Registered Nurses for 25-bed hospital. Minimum salary: $350 with allowance for experience. Registered Nursing Assistants, minimum salary: $250 with allowance for experience. Excellent fringe benefits. Board and room available in residence: $45/m. Apply to: Mrs. G. Gordon, Superintendent, Nipigon District Memorial Hospital, 98 Churchill St., Nipigon, Ontario. 7-87-1

Registered Nurses for 60-bed hospital. Accommodation available in nurses' residence, pleasant working conditions and up-to-date personnel policies. Contact: Director of Nursing Services, Memorial Hospital, St. Marys, Ontario. 7-112-1

Registered Nurses and Registered Nursing Assisttants for well equipped 75-bed hospital in progressive town of 6,500, situated midway between Winnipeg and the Canadian Lakehead. Basic wage Reg.N., $330 and Reg.N.Ass'ts, $230/m. with single room accommodation available in modern nurses' residence. Excellent personnel policies. For further information, please phone or write: The Director of Nursing, Dryden District General Hospital, Dryden, Ontario. 7-36-1

Registered Nurses, Certified Nursing Assistants (IMMEDIATELY) for 40-bed hospital in pleasant town of 5,000. 42-hr. wk. with good rotation shifts, providing long weekends every 4 wks. Good salaries and personnel policies. For further details and application, apply: Administrator, General Hospital, Espanola, Ontario. 7-41-1

Registered Nurses and Certified Nursing Assistants for 160-bed accredited hospital. Starting salary $350 and $240 respectively with regular annual increments for both. Excellent personnel policies. Residence accommodation available. Apply to: Director of Nursing, Kirkland & District Hospital, Kirkland Lake, Ontario. 7-67-1

Registered Nurses and Certified Nursing Assistants for immediate and future vacancies in this 42-bed hospital. Starting salaries $335 and $225, respectively. Accommodation in new residence available. Usual fringe benefits. For full information, apply to: Director of Nursing, New Liskeard and District Hospital, New Liskeard, Ontario. 7-83-1

REGISTERED NURSE AND REGISTERED NURSING ASSISTANT for new 34-bed General Hospital to be opened in December, 1964. Excellent personnel policies. Residence accommodation available. For further information, please phone or write: Administrator, Louise Marshall Hospital, Mount Forest, Ontario. 7-82-1A

Registered Nursing Assistants for well-equipped 42-bed General Hospital located in area known for its wealth of natural resources. The sportsminded person has unlimited activities to enjoy. Starting salary: $230/m. Excellent personnel policies. Accommodation available in well-furnished nurses' residence. For further information, please phone or write: The Director of Nursing, Sioux Lookout General Hospital, P.O. Box 909, Sioux Lookout, Ontario. 7-119-1

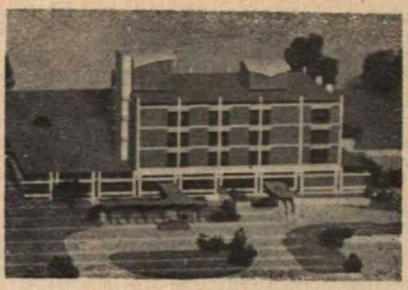
Registered Nursing Assistants for well-equipped active 35-bed General Hospital. Good personnel policies. Hospital is located 35 miles north-west of Toronto. For further information please phone or write: Superintendent, The Cottage Hospital (Uxbridge), Uxbridge, Ontario. 7-135-1

Registered Nurses for General Duty in well-equipped 28-bed hospital, located in growing gold mining and tourist area, north of Kenora, Ontario. Modern residence with individual rooms; room, board and uniform laundry only $45. 40-hr. wk., no split shift, cumulative sick time, 8 statutory holidays and 28 day paid vacation after one year. Salary range $350 - $375. Apply to: Matron, Margaret Cochenour Memorial Hospital, Cochenour, Ontario. 7-29-1

Registered Nurses for General Duty in small sized General Hospital located 30-mi. from Ottawa. Good personnel policies. Apply: Superintendent, District Hospital, Kemptville, Ontario. 7-63-1

Registered Nurses for General Duty in all departments including Premature and New-born Nursery, Isolation, Emergency, Recovery Room, and Intensive Care Unit. Good salary and personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario. 7-73-10

Registered Nurses for General Duty and Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 80,000 people. **Salary: $335 per mo.**, with annual merit increments, plus **annual bonus plan,** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply: Director of Nursing, Memorial Hospital, **Sudbury**, Ontario. 7-127-4



NEW HOSPITAL

AJAX, ONTARIO

110 BEDS

Nursing the patient as an individual

OPENING: OCTOBER 1964

VACANCIES for O.R. Supervisor and O.R. Nurses. General Duty R.N.'s and Registered Nursing Assistants (Union Agreement for Registered Nursing Assistants) in Medicine and Surgery, O.R., O.B.S., Pediatrics. Salaries commensurate with prevailing salaries in Metro Toronto. Consideration for experience and education. Overseas nurses welcome. Personnel recognition and excellent fringe benefits. Professional developments fostered.

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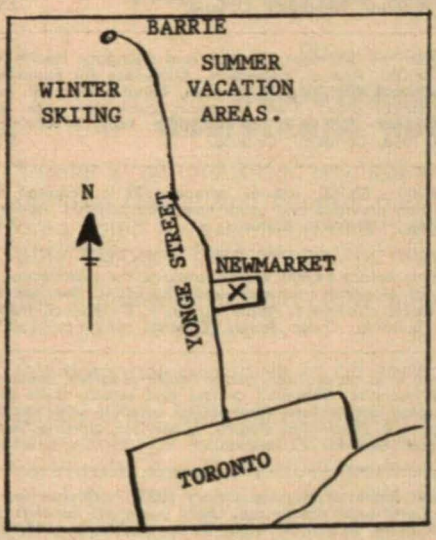
Apply to:

NURSING OFFICE PERSONNEL
AJAX AND PICKERING GENERAL HOSPITAL
Ajax, Ontario

YORK COUNTY HOSPITAL



ONE HOUR FROM DOWNTOWN TORONTO

260-bed Hospital with new facilities including:

INTENSIVE CARE UNIT
SELF CARE UNIT
PSYCHIATRIC UNIT

REGISTERED NURSES: $335-$400 per month

REGISTERED NURSING ASSISTANTS: $230-$265 per month

LIBERAL PERSONNEL BENEFITS INCLUDE:

Pension Plan, Group Life Insurance, Medical and Hospital Insurance, Residence accommodation available.

Please write for further details concerning employment opportunities to:

DIRECTOR OF NURSING, YORK COUNTY HOSPITAL
Newmarket, Ontario

Registered Nurses for General Duty in 100-bed hospital, located 30-mi. from Ottawa, are urgently required. Good personnel policies, accommodation available in new staff residence. Apply: Director of Nursing, District Memorial Hospital, Winchester, Ontario. 7-144-1

Registered Nurses for General Staff in active 300-bed hospital. Apply: Director of Nursing, General Hospital of Port Arthur, Port Arthur, Ontario. 7-106-1

Registered or Graduate Nurses for modern 100-bed hospital located in summer resort district, 40-mi. from Ottawa. Apply: Director of Nursing, Public Hospital, Smiths Falls, Ontario. 7-120-2

General Duty Nurses for 66-bed General Hospital. Starting salary: $335/m. Excellent personnel policies. Pension plan, life insurance, etc., residence accommodation. Only 10 min. from downtown Buffalo. Apply: Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario. 7-45-1

General Duty Nurses for modern 100-bed hospital. Registered Nurses $325-$355/m, Graduates $285-$325/m, 40-hr. wk., benefits include accident, sickness and life insurance, hospital and medical insurance plans, & OHA Pension Plan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario. 7-69-1

General Duty Nurses for 100-bed modern hospital, Southwestern Ontario, 32 mi. from London. Salary commensurate with experience & ability; $325/m basic salary. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital, Tillsonburg, Ontario. 7-131-1

General Duty Nurses for 325-bed fully accredited General Hospital located in downtown area of city. Planned orientation program. Progressive personnel policies. Apply to: The Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario. 7-133-9

General Duty Nurses & Certified Nursing Assistants for new 50-bed hospital with modern equipment, 40-hr. wk., 8 statutory holidays, excellent personnel policies & opportunity for advancement. Tourist town on Georgian Bay. Good bus connections to Toronto. Apply to: Director of Nurses, General Hospital, Meaford, Ontario. 7-79-1

Graduate Nurses and Certified Nursing Assistants (Immediately) for progressive rapidly expanding hospital in central Toronto. Salary commensurate with experience and excellent employee benefits. For specific information please reply in confidence to: The Director of Nursing, The Wellesley Hospital, 160 Wellesley Street East, Toronto 5, Ontario. 7-133-49

Operating Room Nurse for small-sized hospital 30 miles from Ottawa. Good personnel policies. Apply: Superintendent, Kemptville District Hospital, Kemptville, Ontario. 7-63-1A

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, ear, eye, nose and throat and orthopedic surgery. Good salary and personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario. 7-73-10A

Operating Room Nurses (2) and General Duty Nurses for this 150-bed hospital. Salary scales as applicable in Ontario. Recognition for experience. All conventional benefits available. Apply giving details of training and experience to: The Director of Nursing, The Cottage Hospital, Pembroke, Ontario. 7-98-1

Public Health Nurses (Qualified) for generalized program, by Stormont, Dundas and Glengary Health Unit located in the Seaway Valley area. Minimum salary $4,000. Annual increments. Allowance for experience, 5-day wk. Employer-shared (50-50) group insurance, portable OMERS pension plan, Ontario Hospital Insurance and P.S.I. coverage (medical, surgical and obstetrical plan). 3-wk. vacation, cumulative sick leave credits, one-half paid as bonus upon leaving after 3-yr. service. Generous car allowance. Reply in writing to: Dr. John A. Thomson, Medical Officer of Health, Box 1058, Cornwall, Ontario. 7-34-5

PUBLIC HEALTH NURSE (QUALIFIED). Salary range $4,200 - $5,200; annual increment $210. Required in a generalized program in the City of Oshawa. Transportation provided and usual employee benefits. Apply to: D. Fleming, Personnel Officer, Civic Administration Bldg., OSHAWA, Ontario. 7-92-2

Public Health Nurses for a generalized program. Minimum salary $4,000 with allowance for experience. Additional benefits include, OMERS pension plan, 50% of Hospital Insurance and Physicians' Services Blue Plan, cumulative sick leave, 4-wk. vacation, generous travel allowance. Apply to: Dr. F. R. Manuel, Medical Officer of Health, Grey County Health Unit, County Building, Owen Sound, Ontario. 7-94-3

Public Health Nurses with at least two years' experience in a generalized public health program, preferably in Ontario, to work closely with health and welfare agencies, treatment centres and service clubs in rehabilitation of handicapped children. Pre-service orientation with salary. New salary schedule with excellent benefits. Car provided. Apply in writing to: Miss Margaret R. MacMillan, Reg.N., Supervisor, Nursing Service, Ontario Society for Crippled Children, 350 Rumsey Road, Toronto 17, Ontario. 7-133-27

STAFF NURSES FOR 220-BED ACCREDITED HOSPITAL with School of Nursing. Salary $325. Preference for any particular service given every consideration. Post-Basic Certificates recognized. Usual personnel benefits, plus proximity to Ottawa, Montreal and Northern New York State. Apply: Assistant Director of Nursing (Service), General Hospital, Cornwall, Ontario. 7-34-1

BERMUDA

Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 150-bed hospital. Travel allowance paid. For particulars, write: Matron, King Edward VII Memorial Hospital, Bermuda. 13-1-18

GENERAL DUTY NURSES FOR ALL DEPARTMENTS

Gross salary for nurses registered in the Province of Ontario $335 monthly with annual increment $10 monthly to $385.

Salary until registration is established — $305 monthly.

Rotating periods of duty — 40 hour week, 8 statutory holidays annually — Annual vacation 21 days.

Annual sick time 12 days after one year, unused portion cumulative to 36 days.

Hospitals of Ontario Pension Plan.

Ontario Hospital Insurance and Physicians' Services Incorporated, 50% payment by hospital.

Apply:

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO.

THE SARNIA GENERAL HOSPITAL

Offers excellent opportunities for

REGISTERED NURSES AND REGISTERED NURSING ASSISTANTS

Sarnia is an industrial city located midway on the seaway, 60 miles north of Detroit and Windsor and 60 miles west of London. It is a resort area noted for swimming and boating as well as being located a reasonable distance from the skiing resorts in Northern Michigan.

The hospital is modern, fully approved (JCAH), and has recently been expanded to 350 beds.

Positions are available in all services.

Salary scale with annual increments to the maximum. Additional salary allowance for two years or more acceptable experience or postgraduate certificate. Benefits include pension plan, 40-hour week, regular rotation of shifts with premium pay for evenings and nights.

Apply:

PERSONNEL DIRECTOR,
SARNIA GENERAL HOSPITAL, SARNIA, ONTARIO.

QUEBEC

Assistant Head Nurses and Certified Nursing Assistants for 60-bed children's orthopedic hospital. Excellent personnel policies. Apply: Miss Flora M. Lamont, Reg.N., Administrator, Shriners Hospital for Crippled Children, 1529 Cedar Avenue, Montreal 25, Quebec. 9-47-42

Registered Nurses for 30-bed General Hospital, 50 mi. from Centre of Montreal. Excellent bus service. Starting salary: $325/m. Salary increases as recommended by ANPQ. 40-hr. wk. Annual vacation, statutory holidays, 2-wk. sick leave, Blue Cross paid, living accommodation available. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Que. 9-29-1

Operating Room Nurses for 56-bed accredited General Hospital, 38 miles from Montreal. Salary range $355-$385/m. Excellent working conditions, 5 day week, 4 weeks vacation after one year's service. Living accommodation available in modern motel type residence complete with out-door swimming pool. Apply to: Mrs. M. Fearn, Director of Nursing, Barrie Memorial Hospital, Ormstown, Quebec. 9-52-1B

SASKATCHEWAN

Matron for new 14-bed hospital. Salary open for negotiation. Increments and sick leave according to SRNA schedule. Accommodation available in residence. Duties to commence as soon as available. Apply to: Mrs. D. Spark, Secretary-Manager, Hudson Bay Union Hospital, Hudson Bay, Saskatchewan. 10-46-1

Registered Nurses (2) to start immediately for new 13-bed hospital. Basic gross salary $330/m with annual increments. Sick leave and holidays in accordance with SRNA schedule. Apply to: Secretary-Treasurer, Cupar Union Hospital, Cupar, Saskatchewan. 10-21-1

Registered Nurses (2) — Duties to commence as soon as possible. For new completely modern 27-bed hospital. Initial salary $325/m. 40-hr. wk., new modern residence. Excellent working conditions and living accommodation. Apply to: Superintendent of Nursing Services, Kipling Memorial Union Hospital, Kipling, Saskatchewan. 10-59-1

General Duty Registered Nurses (2) for 28-bed hospital. Salary $325 with yearly increments, sick leave, pension plan, maintenance available at nominal rates. For further information apply to: Mrs. E. Paul, Director of Nursing, Union Hospital, Preeceville, Saskatchewan. 10-101-1

Public Health Nurses (required immediately) for Health Department, City of Regina, with 130,000 population, approximately 10 sq. miles in size. Generalized program, good personnel policies, excellent working conditions. Salary range $344 - $437/m, plus car allowance, increasing to $354 - $450 effective January 1, 1965. Must possess a Diploma in Public Health Nursing from a Canadian University. Applications and enquiries should be directed to the PERSONNEL DEPARTMENT, CITY HALL, REGINA, SASKATCHEWAN. 10-109-8

U.S.A.

T.B. SUPERVISOR for two ward unit in General Hospital. Minimum 2 years' experience in T.B. nursing required. Eligible for California registration. Salary $481-$505/m. Living accommodation for single women at nominal charge; modern well-equipped hospital in rural area. 15 working days vacation annually, sick leave, retirement plan including Social Security. Apply: Director of Nurses, Tulare-Kings Counties Hospital, Springville, California. 15-5-45

HEAD NURSES and STAFF NURSES for Orthopedic and Intensive Care Services, for 218-bed accredited General Hospital. Eligible for California registration. Salary $436-$481/m. Living accommodation for single women at nominal charge; modern well-equipped hospital in rural area. 15 working days vacation annually, sick leave, retirement plan including Social Security. Apply: Director of Nurses, Tulare-Kings Counties Hospital, Springville, California. 15-5-45A

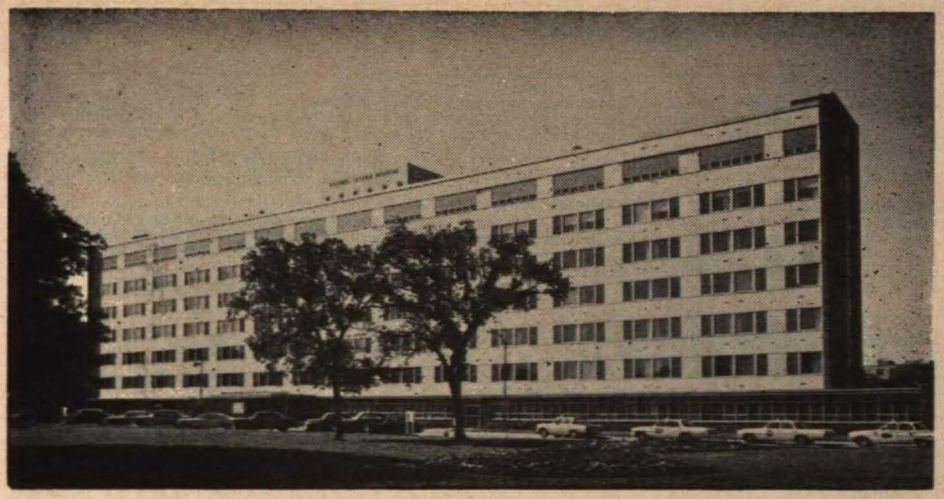
OPERATING ROOM TECHNICIANS for new surgical suite in expanding 245-bed JCAH accredited hospital in So. Calif. resort city. Attractive personnel policies. Apply: Director of Nursing Service, Cottage Hospital, 320 W. Pueblo Street, Santa Barbara, California. 15-5-39B

Registered Nurses for modern 374-bed General Hospital on the beautiful, warm Peninsula, yet only 20-min. from the heart of cosmopolitan San Francisco. Openings in all nursing services including operating room, emergency room, and I.C.U. Excellent personnel policies, many extra benefits and opportunities for advancement. Telephone collect. OXford 7-4061 or write: Director of Personnel, Penninsula Hospital, 1783 El Camino Real, Burlingame, California. 15-5-20

Registered Nurses. Career satisfaction, interest and professional growth unlimited in modern, JCAH accredited 254-bed hospital. Located in one of California's finest areas, recreational, educational and cultural advantages are yours as well as wonderful year-round climate. If this combination is what you're looking for, contact us now! Staff Nurse entrance salary $395 with automatic increase to $455 per mo., supervisory positions at increased rate. Special area and liberal shift differentials paid. Excellent benefits including Blue Cross hospitalization and surgical coverage and liberal personnel policies. Professional staff appointments available in all clinical areas to those eligible for California licensure. Write today: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California. 15-5-12

Registered Nurses for private 278-bed hospital for men, women and children. Staff Nurse salaries from $400 - $465, differentials for evenings and nights. Opportunities in all clinical areas. Holidays, vacations, sick leave, life insurance and health insurance. California registration required. Applications and details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California. 15-5-4

Registered Nurses for 233-bed modern hospital. Positions available — All services, no shift rotation. Liberal benefits, advancement opportunities, educational opportunities in area, equal opportunity employer. Apply: Director of Nursing Service, Kaiser Foundation, San Francisco 15, California. 15-5-57



THE WINNIPEG GENERAL HOSPITAL

is Recruiting General Duty Nurses for all Services

SEND APPLICATIONS DIRECTLY TO

THE PERSONNEL DIRECTOR, WINNIPEG GENERAL HOSPITAL
WINNIPEG 3, MANITOBA

Applications are invited for the position of:

DIRECTOR OF NURSING

OSHAWA GENERAL HOSPITAL

This position will become vacant upon the retirement of our present Director of Nursing. Oshawa General Hospital is a 540-bed Active Treatment hospital which includes medical, surgical, chronic, paediatric and obstetrical units. Our School of Nursing has 120 students.

Expansion plans are presently being studied for all areas of the Hospital. This is a challenging position and applicants with experience in Nursing Service and Nursing Education, with a Baccalaureate degree will be given preference. Starting date will be within the next year.

Please address all enquiries to:

W. A. Holland, Administrator,
OSHAWA GENERAL HOSPITAL,
24 Alma Street, Oshawa, Ontario.

REGISTERED NURSES — General Duty for 84-bed JCAH hospital 1½ hours from San Francisco, 2 hours from Lake Tahoe. Starting salary $420/m. with differentials. Apply: Director of Nurses, Memorial Hospital, Woodland, California. 15-5-49B

Registered Nurses, Staff Nurses for permanent positions, various departments, days, eves., nights. Excellent starting salary, increments, benefits and working conditions in one of the largest and finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California. 15-5-3G

ATTENTION! GENERAL DUTY NURSES 297-bed fully accredited County Hospital located 2-hr. drive from San Francisco, ocean beaches & mountain resorts in modern & progressive city of 35,000. 40-hr. 5-day wk., pd. vacation, pd. holidays, pd. sick leave, retirement plan, social security & insurance plan. Accommodations in nurses' home, meals at reasonable rates, uniforms laundered without charge. Starting salary $395 per mo., plus shift and service differentials. Merit increases to $481/m. Must be eligible for California registration. Write: Director of Nursing, Stanislaus County Hospital, 830 Scenic Drive, Modesto, California. 15-5-42

GENERAL DUTY NURSES for 16-bed emergency hospital. Salary $275 plus room, board and laundry. If it can be arranged to live out the salary is $100 plus the above. 40-hr. wk., 8 paid holidays, excellent working conditions. Yosemite National Park, California, year round recreation area. Apply: Head Nurse, Lewis Memorial Hospital, Yosemite National Park, California. 15-5-57

(a) **Operating Room Nurses** (experienced); basic salary $385 with good financial reimbursement for call. (b) **Obs. Nurses** $385 basic salary with $20 differential for 3-11 or 11-7 shifts. (c) **General Duty Nurses** $375 basic salary; $20 differential for 3-11 or 11-7 shifts. Apply: Director of Nurses, General Hospital, Eureka, California. 15-5-14

OPERATING ROOM NURSES for new surgical suite in expanding 245-bed JCAH accredited hospital in So. Calif. resort city. Attractive personnel policies. Housing allowance for first month. Current valid Calif. license required. Apply: Director of Nursing Service, Cottage Hospital, 320 W. Pueblo Street, Santa Barbara, California. 15-5-39A

Staff Nurses for 245-bed JCAH accredited hospital in southern California resort city. Starting salary $395 - plus $22.50 shift differential. Housing allowance for first month. Current valid Calif. licence required. Apply: Director of Nursing Cottage Hospital, Santa Barbara, California. 15-5-39

Staff Nurses for 300-bed County Hospital. Attractive personnel policies plus differential for specialties, afternoon and night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California. 15-5-3C

Staff Duty positions (Nurses) in private 403-bed hospital. Liberal personnel policies and salary. Substantial differential for evening and night duty. Write: Personnel Director, Hospital of The Good Samaritan, 1212 Shatto Street, Los Angeles 17, California. 15-5-3B

Nurses for new 75-bed General Hospital. Resort area. Ideal climate. On beautiful Pacific ocean. Apply to: Director of Nurses, South Coast Community Hospital, South Laguna, California. 15-5-50

General Duty Nurses for 72-bed hospital. Salary $425/m, fringe benefits. College town, mountainous portion of Colorado. Contact: Superintendent, Alamosa Community Hospital, Alamosa, Colorado. 15-6-1

REGISTERED NURSES: for 75-bed air conditioned hospital, growing community. Starting salary $330-$365/m, fringe benefits, vacation, sick leave, holidays, life insurance, hospitalization. 1 meal furnished. Write: Administrator, Hendry General Hospital, Clewiston, Florida. 15-10-1

General Duty Nurses — Present hospital 55-beds, with new 75-bed hospital to open April, 1, 1965. Located on Lake Okeechobee near west Palm Beach. Liberal personnel policies, 40-hr. wk., bonus at end of first year. Minimum starting salary $380, with differential for evenings and nights. Apply: Director of Nursing Service Memorial Hospital, P.O. Box 928, Belle Glade, Florida. 15-10-3

Help Wanted! Registered Nurse in sunny Florida near West Palm Beach. Starting salary for R.N.'s is $375/m. 40-hr. wk. Good working conditions. New 50-bed hospital under construction. Living quarters available. S.E. end of Lake Okeechobee. Write or call: J. C. Simonds, Administrator, **EVERGLADES MEMORIAL HOSPITAL,** 1749 E. Main Street, Pahokee, Florida. 33476. Phone: 924-5502. 15-10-4

ST. FRANCIS HOSPITAL, MIAMI BEACH, FLORIDA. Positions open for Staff and special departments. $80 a week day shift; differential for evenings and nights. Good vacation policy, paid hospitalization, pension and life insurance plan. Private duty and short term per diem work $20 a day. Accommodations available in nurses' residence. Ocean bathing within walking distance. Must speak English. 15-10-2

REGISTERED NURSES: Excellent opportunity for advancement in atmosphere of medical excellence. Finely equipped, growing 200-bed suburban community hospital on Chicago's famed "North Shore" offers stimulating professional contacts within framework of personal attention. Completely air-conditioned, furnished cottages; two week paid vacation, liberal personnel policies. Starting salary from $410 to $430 days. Differential of $30 for nights or evenings. Contact: Donald L. Thompson, R.N., Director of Nursing, Highland Park Hospital, Highland Park, Illinois. 15-14-3

General Duty Staff Nurses for 215-bed General Hospital, 30-min. from New York City. All shifts, all services. Salary $4,800 to $5,200, depending on experience. Shift differential $540. Living quarters available. Apply: Director of Nursing, General Hospital, Yonkers, New York. 15-33-7A

ST. JOSEPH'S HOSPITAL

Hamilton, Ontario

A modern, progressive, 850-bed hospital, located in the centre of Ontario's Golden Horseshoe, has openings for:

1) **General Staff Nurses in all clinical areas.**

2) **Registered Nursing Assistants in all clinical areas.**

For further information write to:

THE DIRECTOR OF NURSING
St. Joseph's Hospital
Hamilton, Ontario

GUELPH GENERAL HOSPITAL

ACTIVE — 200 BEDS — FULLY ACCREDITED

requires

GENERAL STAFF NURSES
REGISTERED
NURSING ASSISTANTS

Pleasant City of 42,000, one hour from Toronto Via 401. Good personnel policies.

For further details apply to:

THE DIRECTOR OF NURSING
GENERAL HOSPITAL
Guelph, Ontario

PROVINCE OF NEWFOUNDLAND

Department of Health requires Nurses for

(A) St. John's — Applicants should possess certificate in Public Health Nursing.

Salary scale $3,600 - 120 - $4,200 per annum.

(B) Outports—Applicants should possess certificate in Public Health Nursing or have post-graduate training in Obstetrics.

Salary scale $4,500 - 120 - $5,300 per annum.

Uniform allowance is provided. A generalized programme is carried out by all Public Health Nurses.

Applications and/or requests for further information should be forwarded to:

Director
DEPARTMENTAL NURSING SERVICES
Department of Health
Confederation Building
St. John's, Newfoundland
Canada

ASSISTANT DIRECTOR OF NURSING (Education)

For hospital school of nursing with approximately 80 students. University preparation essential.

FOR FURTHER INFORMATION APPLY TO:

Director of Nursing,
CORNWALL GENERAL HOSPITAL,
Cornwall, Ontario.

MEDWAY AND GRAVESEND HOSPITAL MANAGEMENT COMMITTEE

ALL SAINTS' HOSPITAL, CHATHAM, KENT, ENGLAND

THEATRE PUPILS required; a four month course for post registered nurses. Experience in General Surgery, E.N.T. and Gynaecology. Tuition and lectures given, certificate on completion of course. Hospital within easy access of London and the Kent Coast.

PLEASE APPLY TO MATRON.

U.S.A.

Staff Nurses 380-bed hosp. new 120-med.-surg. unit. Trans. pd. 1st class air to Albuq. and return within U.S. in exchange for 1-yr. emp. contract. Come to New Mexico "Land of Enchantment." Career opportunities, largest pvt. JCAH accredited hosp. in state; near U. of New Mexico, R.N. & B.S. pgm. Practical Nurse pgm. accredited state & NAPNE. Vacancies, Med.-Surg. & occasionally O.B., Peds., & O.R., salaries $350 per mo. even., night or O.R. with call; annual increases up to $410; days $340 per mo. with increases up to $400 Rotation from day duty is required only when no person desiring permanent P.M. or night tour is available. Liberal personnel policies include: optional Blue Cross, Discount Hosp. Services, pd. sick leave cumulative to 5 wks., annual physical exam., vacation 1 yr. — 2 wks., 5 yrs. — 3 wks., 10 yrs. — 4 wks. Active in-service program. Occasional vacancy hosp. owned appts. New Mexico licensure as professional nurse and U.S. citizenship (or Immigration Visa) required. Write or call collect: Mrs. Emily J. Tuttle, Dir. of Nursing, Presbyterian Hospital Center, 1012 Gold, S.E., Alburquerque, New Mexico. Phone 243-5611. 15-32-3

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetrics and pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th Street, Cleveland 6, Ohio. 15-36-1D

Staff Nurses for modern 400-bed tuberculosis hospital, suburban Cleveland, Ohio. Monthly salaries start at $410 with semi-annual increments. Extra for night and relief duty. 5-day work wk., 3-wk. paid vacation, 6 paid holidays, liberal sick leave, comfortable accommodation in nurses' residence at low rate. Learn and earn at a progressive accredited hospital in a growing community. Write: Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio. 15-36-1E

Registered Nurse (Scenic Oregon vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary starts at $411/m. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomach Hospital, Portland, Oregon. 97201. 15-38-1

STAFF NURSES All Clinical Services. Starting salary $382 for day shift; $419 for evening and night shifts; opportunities for advancement. Personnel policies, sick leave, retirement plan, 3-wk. vacation and laundry of uniforms. Orientation and in-service programs. Housing available on Campus. Apply: Director, Nursing Service, University of Texas Medical Branch Hospitals, Galveston, Texas. 15-44-5

Staff Nurses Outstanding opportunities for career development! Expanding 320-bed medical center in summer and winter resort area. Opportunities include, maternity, operating room, pediatrics and clinical research nursing. Active inservice program; scholarship aid available for continuing education through University of Vermont Department of Nursing. Attractive New England community. Apply: Gilbert R. Lubbers, Assistant Administrator, The Mary Fletcher Hospial, Burlington, Vermont. 15-46-3

Staff Nurses, University of Washington 320-bed modern, expanding Teaching and Research Hospital located on campus, offers you an opportunity to join the staff in one of the following specialties: Clinical Research, Premature Center, Open Heart Surgery, Physical Medicine, Orthopedics, Neuro-surgery, Adult and Child Psychiatry in addition to the General Services. Salary: $400-$462. Unique benefit program includes free University courses after six months. For information on opportunities write to: Mrs. Ruth Fine, Director of Nursing Services, University Hospital, 1959 Pacific Avenue, Seattle, Washington. 15-48-2D

Registered Nurses in a small community hospital with rapidly expanding services. Accredited by Joint Commission Hospital Accreditation. Salary meets American Nurses' Association scale. Travel time 60 minutes from metropolitan area. Inquire: Director of Nurses, St. Croix Falls Hospital, St. Croix Falls, Wisconsin. 15-50-1

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Newly expanded 350-bed hospital. Progressive patient care concept.

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General Staff Nurses registered in Ontario $335 - $400 per month. Registered Nursing Assistants $235 - $271 per month.

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High quality patient care and friendly working environment, personnel recognition and professional development.

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At a 300-bed air-conditioned General Hospital presently under construction. Opening date scheduled for July 1966. Applicants with experience and Bachelor's Degree in Nursing Service Administration will be given consideration.
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Required for the Children's Services of the

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This unit includes services for emotionally disturbed adolescents and the mentally retarded. A Director of Nursing for the services and supervisors are required. Preference will be given to senior personnel with university degrees or diploma in teaching, administration and clinical supervision. Suitable candidates will also have teaching responsibilities.

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General Duty Nurses fo rall departments, also Operating Room Nurses required in modern 340-bed fuily accredited hospital.
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General Hospital of 109 beds, with forthcoming expansion program, located in Northwestern B.C. requires Director of Nursing.

Salary is open and dependent on qualifications and experience. Residence accommodation available if desired.

Apply giving full particulars of education and experience to:

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REGISTERED NURSES

for **GENERAL DUTY** positions

Planned orientation and inservice education programs.

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PROVINCE OF NEWFOUNDLAND

Department of Health requires for

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(A) Charge Nurses — postgraduate experience required.

Salary scale $4,900-120-$5,800 per annum from which there will be a deduction for board and lodging.

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Uniforms are provided without charge. Transportation for successful applicants, from outside the Province, is provided on the basis of a one year contract.

Cottage Hospitals vary in size from 12 to 67 beds and provide health services for the people of the outport areas of Newfoundland.

Applications and/or requests for further information should be forwarded to:

Director
DEPARTMENTAL NURSING SERVICES
Department of Health
Confederation Building
St. John's, Newfoundland
Canada

REGISTERED NURSES
and
REGISTERED NURSING ASSISTANTS

for

375-bed accredited General Hospital. Registered Nurses salary range $325-$390 per month with consideration for contemporary experience or postgraduate courses.

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600-bed fully accredited hospital provides experience in Operating Room, Recovery Room, Intensive Care Unit, Pediatrics, Orthopedics, Obstetrics, General Surgery and Medicine.

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ST. JOSEPH'S HOSPITAL
30 The Queensway, Toronto 3, Ontario

HOSPITAL FOR MENTAL AND NERVOUS DISEASES
ST. JOHN'S, NEWFOUNDLAND

Applications are invited for the positions of **ASSISTANT DIRECTOR OF NURSES (Teaching)** and a **HEAD NURSE** for the Teaching Department of a large Provincial Mental Hospital Service.

The Education Department provides teaching for Affiliating Nursing Students, Male and Female Psychiatric Nursing Assistants, and a Postgraduate Psychiatric Diploma Course for Registered Nurses.

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Write to:

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For 92-bed hospital, expanding to 155 beds. Excellent opportunity for Registered Nurse with P. G. Course or Extensive O. R. Experience.

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Leamington, Ontario

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40 hour week — Pension plan
Good salaries and Personnel Policies

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NURSES

KENORA, ONTARIO

This resort town of 14,000 people has just opened a section of its new 100-bed hospital and in the not too distant future will be opening the second section for which nurses are needed. The hospital is wonderfully located on the shores of beautiful Lake of the Woods in Ontario. In the summer, we have activities in swimming, boating, fishing and golfing and in the winter there is skating, curling, tobogganning, skiing and ice fishing.

A nurses' residence is available at a reasonable rate of $20 per month for private room or $15 per month for a double room. Cafeteria services are available at cost as well as a kitchen in the nurses' residence. Separate personnel policies for nurses are available and will be mailed on request. The starting salary is $330 per month. Eight statutory holidays, sick leave, three weeks vacation with pay are some of the benefits of these policies.

All applications will be treated with courtesy and privacy.

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Director of Nursing
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(1) Head Nurse for 32-bed Pediatric unit;

(2) Supervisor for unit administration on medical wards;

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(5) General Staff Nurses in all departments.

Good personnel policies. Salary commensurate with experience and preparation.

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Director of Nursing
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required for

A 163-bed General Hospital

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PORT COLBORNE, ONTARIO

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REGISTERED NURSES

For recently expanded General Hospital of 166 beds within easy driving distance of American and Canadian metropolitan centres. Salary $335 per month with five annual increments of $120 per year. Consideration given for previous experience obtained in Canada. Accommodation available in nearly completed apartment residence, on hospital property, facing the lake.

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For 87-bed Geriatric Hospital. Good personnel policies. Applications are invited from nurses who are interested in Medical and Rehabilitation Nursing.

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100-bed General Hospital, postgraduate trainning not essential. Excellent salary and benefits, beautiful residence available at very reasonable rate.

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Requires

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and

REGISTERED NURSING ASSISTANTS

Modern 381-bed, fully accredited Hospital Excellent personnel policies, O.H.A. Pension Plan.

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SALARY $415 to $480

(Commensurate w/experience)

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For more information write:

Personnel Director,
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TEmple 3-2000

COUNTY OF RENFREW HEALTH UNIT

This new Health Unit began July 1st, 1964.

Applications will be received for:

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Please state qualifications, experience, salary expected and date available:

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County Administration Building,
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Excellent Opportunities

SUPERVISORS
HEAD NURSES
STAFF NURSES

BILINGUAL PREFERRED

Write for details:

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WANTED IMMEDIATELY

FOR NEW HOSPITAL EXTENSION

Registered Nurses interested in Obstetrical and Gynecological Nursing, also Infant Care, Postgraduate Course an asset.

Apply to:

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Canora Union Hospital, Canora, Sask.

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Requires

GENERAL DUTY NURSES

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PERSONNEL DIRECTOR,
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110-bed "HOME FOR THE AGED" with 50-bed bed-care wing. Located on Grand River, Niagara Peninsula within 1 hour's travel to Hamilton, Niagara Falls and Buffalo, N.Y. Modern staff quarters optional.

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82-bed hospital. Situated in the Niagara Peninsula. Transportation assistance.

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CHARGE NURSES — OPERATING ROOM
GENERAL STAFF

Apply to:

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For a new 40-bed Hospital with Nurses' Residence. **Nurses—Salary: $340-$390** according to experience. 3 semi-annual increments of $10 each. **C.N.A.'s—Salary: $225-$255** according to experience. 3 annual increments of $10 each.

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With postgraduate course in Operating Room Technique and management.

Required for 100-bed modern hospital.

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Instructor in Nursing Assistant Centre: Minimum salary—$400; Supervisor of Pediatric Ward: Minimum salary—$400; Supervisor of Nursing Office: Minimum salary—$420; Head Nurses: Minimum salary—$360; General Duty Nurses: Minimum salary—$340:

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OTTAWA CIVIC HOSPITAL

requires

GENERAL STAFF NURSES

for

OPERATING ROOM
MEDICAL
SURGICAL
OBSTETRICAL AND
PSYCHIATRIC
} DEPARTMENTS

Apply:

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Assistant Director and Administrator
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Degree Course in Basic Professional Nursing

Candidates for the degree of Bachelor of Nursing are required to complete 2 years of university work before entering the clinical field, and one year of university work following the basic clinical period of 30 months. On completion of the course the student receives the **Degree** of Bachelor of Nursing and the **Professional Diploma** in either Teaching in Schools of Nursing or Public Health Nursing.

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(c) Nursing Service Administration

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DIRECTOR, SCHOOL OF NURSING
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A SIX MONTH CLINICAL COURSE IN

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Offers to Graduate Nurses
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Tuberculosis Nursing
including Immunology, Prevention, Medical and Surgical Treatment

1. Full series of lectures by Medical and Surgical staff.
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Director of Nursing
NOVA SCOTIA SANATORIUM
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Students are granted a diploma at the completion of the first year of the program leading to the degree of Bachelor of Nursing. All first-year students elect to study in

PUBLIC HEALTH NURSING

or

TEACHING AND SUPERVISION IN ONE OF THE FOLLOWING:

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A two-year program for nurses with McGill Senior Matriculation or its equivalent.

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leading to the degree Bachelor of Science in Nursing

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1. (a) Six month clinical course in Obstetrical Nursing.

   Classes—September and February.

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3. Six month course in Theory and Practice in Psychiatric Nursing.

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For information and details of the courses, apply to:

Director of Nursing
Royal Victoria Hospital
Montreal, P.Q.

UNIVERSITY OF BRITISH COLUMBIA

School of Nursing

DEGREE COURSE IN BASIC NURSING

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Both of these courses lead to the B.S.N. degree. Graduates are prepared for public health as well as hospital nursing positions.

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UNIVERSITY OF B.C.
Vancouver 8, B.C.

Test Pool Examinations

for

Registration of Nurses

in

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To take place on February 17, 18 and 19, 1965 at Halifax and Sydney. Requests for application forms should be made at once and forms must be returned to the Registrar **not later than January 8, 1965** together with:

1. **Diploma of School of Nursing;**
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Applications received after this date will not be accepted. No undergraduate may write unless he or she has passed successfully all final school of nursing examinations and is within nine (9) weeks of completion of the course in nursing.

NANCY H. WATSON, R.N.
Registrar
THE REGISTERED NURSES' ASSOCIATION OF NOVA SCOTIA
6024 QUINPOOL ROAD, HALIFAX, N.S.

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The Hospital is situated close to many places of interest in London.

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DEGREE COURSE IN BASIC NURSING (B.Sc.N.)

A Four-Year Course which prepares students for all branches of community and hospital nursing practice and leads to the degree, Bachelor of Science in Nursing (B.Sc.N.). It includes studies in the humanities, basic sciences and nursing. Bursaries, loans and scholarships are available.

For additional information, write to:

SCHOOL OF NURSING,
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for
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In operating room techniques. Six months. Courses begin February 28, 1965 and August 15, 1965. Room, meals, laundering of uniforms and monthly stipend provided.

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Department C, 1900 West Polk Street,
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Registered Nurses a 16-wk. supplementary program in pediatric nursing. Classes are admitted **January, May and September.**

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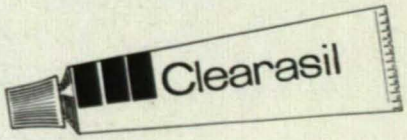

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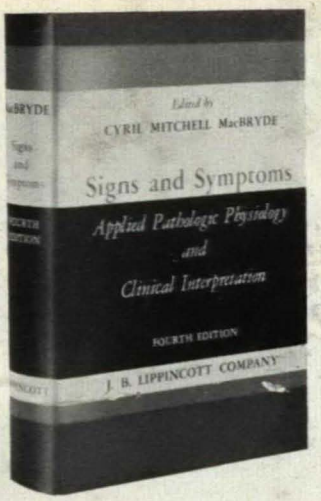

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